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PREPAREDNESS FOR THE PERSIAN GULF

HEARING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

SPECIAL HEARING

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PREPAREDNESS FOR THE PERSIAN GULF

TUESDAY, JANUARY 22, 1991

U.S. SENATE,
SUBCOMMITTEE ON VETERANS AFFAIRS, HOUSING AND URBAN DEVELOPMENT, AND INDEPENDENT AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:33 a.m., in room SD-138, Dirksen Senate Office Building, Hon. Barbara A. Mikulski (chair) presiding.
Present: Senators Mikulski, Leahy, and Bond.

DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF HON. EDWARD J. DERWINSKI, SECRETARY OF VETERANS AFFAIRS

ACCOMPANIED BY:

DR. JAMES W. HOLSINGER, JR., CHIEF MEDICAL DIRECTOR
RAUL CARROLL, GENERAL COUNSEL
BARBARA L. GALLAGHER, MEDICAL CENTER DIRECTOR
JOSE R. CORONADO, MEDICAL CENTER DIRECTOR
JOHN FEARS, ASSOCIATE CHIEF MEDICAL DIRECTOR FOR RESOURCE MANAGEMENT
LEONARD ROGERS, ASSOCIATE CHIEF MEDICAL DIRECTOR FOR OPERATIONS
JOSEPH GRAY, ASSOCIATE CHIEF MEDICAL DIRECTOR FOR EXTERNAL RELATIONS
DR. RAY BONNABEAU, DIRECTOR, EMERGENCY MEDICAL PREPAREDNESS OFFICE

OPENING STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI. The Appropriations Subcommittee for Veterans, Housing, and Independent Agencies will come to order.

Today, the subcommittee meets amidst the reality of war in the Persian Gulf to review one of the most sobering aspects of our military readiness: the capacity of our health care system to treat those brave men and women who have been or will be in Operation Desert Storm.

There are no honorary members of American veterans, nor are there any honorary members among our Armed Forces now serving in the gulf. Both groups are made up of ordinary men and women called to do extraordinary things. They have earned their stripes and they have certainly paid their dues. They are the heroes of our time.

Our veterans have been to Europe, the beachheads of the Pacific, the mountains of Korea, the jungles of Vietnam, Beirut, and now they are in the sands of Saudi Arabia, and are at sea in the Persian Gulf. These patriots have done what they had to do for our democracy and our way of life.

Now, it is our turn, as a democratic society, to say thank you to them, not with words, not only with words and with parades, but with our deeds. For these young, brave Americans who today risk their lives to defend the world against a ruthless dictator in the Mideast, we have a moral obligation to give them the best health care modern medicine can provide if they need it.

In 1982, the Congress passed a law that requires DOD and the Department of Veterans Affairs to develop such a plan if there were to be a major military conflict. This plan was developed in 1983, but Operation Desert Storm will be the first real test.

The fundamental issue we will explore today is quite straightforward: the plan which DOD and the VA have developed for providing health care as fit for duty as the men and women of Operation Desert Storm.

We will focus on four principal questions. First, what is the plan now in place to provide both emergency and long-term medical care to American troops injured in Desert Storm, will it work, and what role does the Department of Veterans Affairs play in that plan?

Second, does the VA health care system, already strapped by tight budgets, have sufficient resources, enough people, supplies, and equipment to treat both the casualties from the gulf and still meet its obligations to the veterans who now use its VA medical centers?

Third, what role will civilian hospitals, particularly with highly specialized medical teams and equipment—trauma, burn units, spinal cord—play in assisting DOD and the VA in the treatment and long-term care of our injured troops?

Fourth, has the mobilization of many of the VA's most experienced doctors and nurses for Operation Desert Storm adversely affected the care being given to American's current veterans?

CONGRESSIONAL SUPPORT PLEDGED

In exploring these questions, everyone should know that this Congress and this U.S. Senator fully support our troops now fighting in the Persian Gulf and we are prepared to do everything possible to make sure that our troops have the care they deserve and what we have promised them.

Just before Christmas, I visited with a group of soldiers from Maryland at the Aberdeen Proving Ground as they prepared for deployment in the gulf. They were medics and they were maintenance people. When I was leaving our meeting and talked to the soldiers, I said, "What would you like me to tell the Congress and what would you like to be sure I do." They said, "Whatever you do, do not abandon us. Do not abandon us."

Well, I made that commitment to those men and women at Aberdeen, and I think all Members of Congress have made that commitment. We are going to support the troops in the battlefield with

the bullets they need, but if they are injured, we are going to support them with the beds that they need.

So today, we are going to conduct this hearing and listen to our experts tell us what this plan is. I know this is the first of numerous hearings, and we will want to move right on into the topic.

Senator Alan Cranston, the chairman of the Senate Veterans Committee, should be commended for asking the VA inspector general to begin reviewing the effectiveness of the existing plan, and we will look forward to working with him.

REPROGRAMMING NEEDS

In addition, the chairman of the full Appropriations Committee, Senator Byrd, has indicated that he intends to hold hearings at the full committee level on supplemental appropriations for Desert Shield. As a result, our hearing today will not focus on the supplemental needs, but the possibility of reprogramming needs.

It is my hope that today's hearing, if it bears out the need for reprogramming, or that VA might have a cash-flow problem in meeting its needs, we look forward to working with the Department and our colleague, chairman of the Defense Appropriations Subcommittee, Senator Inouye, who is working with us on these issues.

We want to welcome Secretary Derwinski and his team this morning before the subcommittee. We thank you for your willingness to testify on such short notice and look forward to your testimony.

Before we begin, I want to note that the subcommittee has a new member, and we welcome Senator Kit Bond, a former Governor, a very active Senator, someone that I certainly know is committed to the troops.

And Senator, I wonder if you have an opening statement you would like to make.

PREPARED STATEMENTS

In addition, staff has received statements from Senator Kerrey and Senator D'Amato. Without objection, they will be placed in the hearing record at this point.

[The statements follow:]

STATEMENT OF SENATOR KERREY

I commend the chair of the subcommittee for holding this hearing.

In human terms, there is little more important than ensuring that we are able and ready to treat the victims, heal the wounds, calm the stresses and fears which afflict those we have asked to risk their lives and, literally, suffer the consequences.

I can speak from experience. I can say that I know what it is to be assured that someone is there to help. I know what it means to family and friends to know that the care is there.

We have asked some 425,000 of our men and women to put their lives on the line in the desert sand. We have asked them to go far from home, into an alien culture, into a battlefield which presents the possibility of being far different from those previously encountered. We have asked them to face an enemy which may not engage in what we consider usual means of war. We do not know what the future holds.

I have talked with many families who have husbands, wives and children in the Persian Gulf. I have watched and read of the Reserve units from my State which have been called to duty. I have seen the interviews with family members at various

bases throughout our country. I know that there is limited assurance which we can offer them.

We have talked with the VA hospitals in Nebraska. My State staff attended a briefing on contingency planning at Omaha. We have checked with Lincoln, which like Omaha has a primary designation, and with Grand Island which has a secondary designation. We will continue to be in contact with them.

But, I appreciate the efforts of the Department of Veterans Affairs; again I commend the chair of the subcommittee for pursuing this matter, and I assure you of my support for whatever action is necessary by this subcommittee to guarantee that we provide the best care which we can.

STATEMENT OF SENATOR D'AMATO

Madam Chair, I commend you for convening this hearing on the VA's preparedness to support the Department of Defense in providing medical care to our men and women who are serving in the Persian Gulf.

While we're all hoping and praying that American casualties in the gulf will be kept to an absolute minimum, it is vital that our medical infrastructure be prepared for any eventuality.

To enhance our preparedness for casualties in the event of war, Congress, in 1982, enacted the Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act. This law established the VA as the primary backup to DOD for medical care in any war or national emergency involving the Armed Forces.

Pursuant to this law, the VA has designated 80 VA medical centers as primary receiving centers to accept incoming DOD casualties. Eight of these centers—10 percent of the total—are located in New York.

Given the relative concentration of these centers in New York, I hope Secretary Derwinski will specifically address the role that New York's veterans hospitals will play should the VA activate its contingency hospital system. In addition, I have several questions relating to the VA's preparedness to deal with specific injuries, and its efforts to ensure continuity of care for current veterans.

Again Madam Chair, I commend you for holding this hearing, and I look forward to the testimony of Secretary Derwinski.

Thank you, Madam Chair.

STATEMENT OF SENATOR BOND

Senator BOND. Madam Chair, it is a pleasure to join you on this committee. I have looked forward to it for some time. We know we are in tight financial circumstances, and I am delighted to see that the subcommittee has not wasted a great deal of resources on preparing the nameplates in front of us today. [Laughter.]

I would like to welcome Ed Derwinski, as a Senator, for obvious partisan reasons, and we are very pleased to have him here as the Secretary of the VA.

Madam Chair, I totally agree with your strong words of support for our men and women fighting in Desert Storm, as well as for those veterans in previous combat whose needs we will not forget as we look to the new and challenging problems that may face us in Desert Storm.

We have heard a great deal from the fine VA facilities in the State of Missouri. We have concern about the allocation of resources. Many of the personnel at the hospitals, particularly nurses, are in the Reserves and have been called up. We look forward to learning from the VA how they are going to reallocate, or what needs they see to reallocate, resources to make sure that existing facilities are well staffed.

With that, again, I thank you for calling this hearing and I join you in the very strong words of support that you have provided for our troops. And I look forward to hearing Secretary Derwinski.

Senator MIKULSKI. Thank you, Senator Bond. We will have you a nameplate. I have also got your number.

Senator BOND. It is easy, it is listed.

Senator MIKULSKI. Secretary Derwinski, why do you not begin your testimony, but I think it would also be helpful if you introduced your team.

Secretary DERWINSKI. Thank you, Madam Chair. First, I have a complete statement which I would ask to insert in the record in full, and I will be rather brief because I do want my experts, who are flanking me, to give you the very precise information and details they have been working on.

INTRODUCTION OF ASSOCIATES

Dr. Jim Holsinger, on my left, has been, as Chief Medical Director, has been the man most obviously involved in putting our programs together. And I should add that by interesting coincidence, he is also a major general in the Army Medical Reserve. As such, he knows military medicine, and we have been able to maximize our cooperation with the military medical leaders. I think that is one of the strengths of our program, is the fact that we do have people in our leadership who understand military medicine, and thus, the coordination and team work, we believe, will be maximized if necessary.

On my right, Mr. Raul Carroll is our general counsel and will be pleased to answer any questions you have on the legal aspects of our program.

And then, Ms. Gallagher on my left and Mr. Coronado on my far right, are two of our medical center directors. They both come from two of our major facilities. They can tell you exactly how we are preparing at the grassroots level, should the occasion arise that they would have to handle patients assigned to them under this program.

Now then, we do have almost every expert in the Department here behind us, and Dr. Holsinger and Mr. Carroll would call on them, if needed, depending on your line of questioning.

RECEIVING CENTERS

We have designated 80 of our larger medical centers as primary receiving centers to accept incoming DOD casualties. These are generally the VA's larger, more complex, highly affiliated facilities, which are best suited to accept incoming casualties. Another 79 VA hospitals will serve as secondary support centers. We intend and we feel we are very well prepared to meed out responsibilities to provide needed medical care to active duty military casualties if they develop.

We will continue, of course, to give priority care to veterans with service-connected disabilities and patients in need of emergency care. This care will continue automatically when those service men and women are discharged.

And may I make the point, in some process, if there are casualties, the military will decide when they give them their discharge. If they are in our system they are automatically then eligible for all the service that we would continue to provide to them in their

new status as veterans. And all veterans will receive care in accordance with existing eligibility rules.

Upon notification from Secretary Cheney, the Chief Medical Director will activate the contingency hospital system, and Dr. Holsinger will go into detail with you on the preciseness of that program.

IMPACT OF CALLUP

Then I believe we should emphasize, and you did raise the question in your opening comments, the impact on the VA of the callup of Reserves and National Guardsmen. As of Friday, I believe, we have had 1,886 employees, approximately 1 percent of our health care work force, mobilized for military duty. The impact has been manageable, to date.

A few medical centers have used temporary hiring to replace personnel losses and our medical center directors will ensure that appropriate medical staff and support resources and supplies, et cetera, are there to treat returning casualties when available.

I also would like to add, even though this is not the thrust of your hearing, that we are also conscious of the fact that we will have to provide personal counseling, claims assistance, and claims processing for service men and women wounded or injured in Operation Desert Storm. Therefore, our veteran services staff will be diverted from their regular duties and be assigned to military medical facilities as needed to expand the service for counseling and claims assistance. So we will be prepared to serve the servicemen returning from the battle theater in the most effective possible fashion.

In addition to that, for the record, I would like to emphasize that our national cemetery system had developed priority policies and procedures for all national cemeteries, as well as for headquarters activities with oversight over field operations and for processing the delivery of headstones and markers.

VA MEETING CHALLENGE

The VA, across the board, is alerted and ready to meet the challenge that may be imposed upon us. We understand the enormity of the challenge that we may face, and I want you to know that I am confident that our team of experts in the last, almost 6 months now, has put together a very effective program. Dr. Holsinger has given a great deal of his personal time, and I emphasized earlier his own personal experience as a major general in the military medical service—Army service. Therefore, I think we are very effectively prepared at this time to meet the responsibilities that may be developed.

You are aware, I am sure, Madam Chair and Senator Bond, that there have been some technical problems with reporting mechanisms. These problems have been addressed directly by the Chief Medical Director and his staff, and I believe that, as of this presentation, we have the records and planning down to the point where they will most effectively be able to serve our servicemen, veterans, as called upon.

With that, I would like to yield to Dr. Holsinger for his presentation, if I may, Madam Chair.

[The statement follows:]

STATEMENT OF EDWARD J. DERWINSKI

Madam Chair and Members of the Committee,

Thank you for the opportunity to discuss VA's role as primary backup to DOD in providing medical care to returning casualties from Operation Desert Storm. In addition, I will share with you some of the contingency planning for casualty assistance and services.

Congress authorized this fourth mission for the VA medical program with the passage of the "VA/DOD Health Resources Sharing and Emergency Operations Act" in 1982. During 1982 and 1983, VA entered into agreements with DOD on the specifics of VA's support role. Since that time, DOD and VA have periodically updated and conducted exercises of these plans.

We have designated 80 of our larger medical centers as primary receiving centers to accept incoming DOD casualties. These are VA's larger, more complex, highly affiliated facilities, which are best suited to accept incoming casualties. Another 79 VA hospitals will serve as secondary support centers to back up the primary receiving centers and to maximize availability of beds for returning casualties.

The Veterans Health Services and Research Administration (VHS&RA) has developed an operations plan that delineates line and staff roles and responsibilities at each level of the organization: at Central Office, in the regions, and at medical centers. This is a carefully monitored operation, subject to special oversight by Dr. James Holsinger, the Chief Medical Director. The major goal is to provide the maximum number of staffed beds to active duty military casualties in as short a time as possible, while continuing to perform VA's mission of providing care to eligible veterans.

We will meet our responsibilities to provide needed medical care to active duty military casualties sent to us by DOD. This care will continue automatically when those servicemen and women are discharged and require ongoing treatment for service-connected disabilities. We will continue to give priority care to veterans with service-connected disabilities and patients in need of emergency care. All veterans will receive care in accordance with existing eligibility rules.

Should the need arise to make beds available for active duty casualty patients, veteran patients may be discharged if medically stable from

primary receiving centers and/or transferred to other VA or community hospitals. Continuity of care for these individuals will be maintained.

Upon notification from Secretary of Defense Cheney, I will direct the Chief Medical Director to activate the Contingency Hospital System. While Emergency Operations Centers will be established and operated 24 hours a day, 7 days a week at both the Central Office and Regional levels, we intend to accomplish our mission using the existing organization and lines of authority. The Chief Medical Director and his top management team in Central Office, the Regional Directors and medical center directors will be responsible for the effective implementation of the contingency system in conjunction with fulfilling their ongoing management responsibilities for the day-to-day operations of VA medical centers.

The flow of casualties will be determined by the Armed Services Medical Regulating Office (ASMRO) located at Scott AFB, Illinois, which would track the number of beds available at both VA and DOD hospitals on a daily basis. Since the initiation of Operation Desert Storm, VA has been assessing its bed capability weekly. Since January 10, 1991, every medical center director has been supplying VACO with daily updates on the number and type of hospital beds available for incoming casualties at that medical center. Currently, our reported bed capability for military casualties indicates that approximately 8,053 beds can be made available within 24 hours, and approximately 15,010 beds within 72 hours.

I am aware that there have been some technical problems with the reporting mechanisms. The Chief Medical Director and his staff are working diligently to correct them. This information will be shared with ASMRO on a daily basis prior to actual activation of the VA/DOD Contingency Plan.

At a minumum, the following activities will be implemented at each medical center once the VA Contingency Plan has been activated:

- o provision clinical/administrative patient reception support together with transportation of casualties to VA primary receiving centers;
- o establishment and maintenance of necessary record keeping together with tracking of financial expenditures; and
- o establishment of contact points for family, media and public inquiries.
- o postponement of elective admissions and procedures;
- o early discharge and outplacement of VA hospitalized patients to community or secondary VA hospitals;

We have had 1,923 employees, which constitutes approximately 1% of our health care work force, mobilized for military duty. The impact has been manageable. A few VAMCs have used temporary hiring to replace personnel losses. Medical center directors will ensure that appropriate medical staff and support, resources, transportation, supplies, and equipment necessary to treat returning casualties are made available.

We have procedures in place to monitor the financial aspects of the contingency hospital operations. VA has met with all three branches of the military and has worked out the details of a common billing plan and the rates of reimbursement. A computerized tracking system has already been implemented to collect data from each VA medical center. This system will produce a consolidated national bill reflecting each branch of service on a monthly basis. DOD has assured us timely reimbursement.

While the focus of the Committee's attention is on our preparedness in the field of medical care, we are also mindful of the need to expedite the processing of benefits for these servicemen and women and their families. And of course, our cemetery system stands ready to provide services to those families who opt to have loved ones buried in a national cemetery.

The Veterans Benefits Administration is prepared for its special responsibilities. Our Veterans Services Divisions work in partnership with the military service departments' casualty assistance program. Detailed information on those killed in action will be received at a central control point in VA Central Office and dispatched to involved regional offices. Veterans Services staff coordinate efforts with the assigned military casualty assistance officers to assure complete and rapid information and claims assistance to surviving family members. Any Operation Desert Storm death claims will receive priority processing. This, of course, includes priority processing of life insurance proceeds by the Office of Servicemen's Group Life Insurance.

We have also prepared for the delivery of expedited personal counseling, claims assistance and claims processing for servicemembers wounded or injured in Operation Desert Storm combat. Portions of Veterans Services staffs will be diverted from regular duties to assignments at military medical facilities or, as needed, to an expanded VBA presence at our own medical centers. A special control system for counseling and claims assistance has been developed and dispatched to regional offices for implementation. Additionally, eight regional offices have been designated as central processing offices for the adjudication of Operation Desert Storm

disability claims. This will assure expedited processing while causing little or no disruption to adjudication work at most regional offices.

In response to Operation Desert Storm, the National Cemetery System has developed priority policies and procedures for all national cemeteries, as well as for headquarters activities with oversight of field operations and for processing and delivery of headstones and markers. The NCS has established liaison and coordination with the Casualty Assistance Office and will bury all remains based on notification from that office.

Individual cemetery directors will do everything possible to serve the families of any member of the armed forces who dies on active duty. They will accommodate the next-of-kin's request for date and time of burial, including weekend or holiday burial, if necessary. They will maintain close working relationships with military commands to ensure that honors are provided at burials, reflecting the utmost respect, and will assist with arranging for chaplain and other services associated with the burial.

While the challenge before us is enormous, I am confident VA will continue to fulfill its primary mission to provide quality health care services to veterans and meet its commitment to receive and treat active duty military casualties. I am equally confident that the various benefit programs to which veterans of Operation Desert Storm or their survivors may be entitled will be delivered to them with compassion and speed.

Madam Chair, VA stands ready at this time to effectively serve those servicemen and women assigned to us. When they acquire veteran status, we will meet our responsibility of continued service to them.

I believe that, as a result of having to meet our legal responsibilities at this critical time, we have become a better prepared system as we geared up to provide the additional medical care we may be called upon to render.

TESTIMONY OF DR. JAMES W. HOLSINGER, JR.

Senator MIKULSKI. Please.

Dr. HOLSINGER. First Senator, I would like to introduce some of the individuals that are here with me in case we have to call upon them. Mr. Wayne Hawkins is the Deputy Chief Medical Director for Operations and Administration. Mr. John Fears is the Associate Chief Medical Director for Resource Management. Mr. Leonard Rogers is the Associate Chief Medical Director for Operations, and Mr. Joseph Gray is the Associate Chief Medical Director for External Relations, a major general in the U.S. Army Reserve assigned to Army Deputy Chief of Staff for Operations and Plans. Dr. Ray Bonnabeau is the Director of the Emergency Medical Preparedness Office, a major general in the U.S. Army Reserve, Deputy Surgeon General for Manpower and Reserve Affairs.

So, if we have need of their expertise, they are here to make sure that we are able to answer any questions you might have.

Senator MIKULSKI. Did you have anything else you wanted to say?

Dr. HOLSINGER. I would be perfectly willing to answer any questions on how the system works.

Senator MIKULSKI. Senator Bond, the practice that we follow in the subcommittee is that we each take about 10 minutes. I am going to ask two overriding questions that are basically generic to the committee and then some of my own, and then you and I can kind of rotate back and forth.

My first question is to be sure we all really understand how the plan works. If you could take me, Mr. Derwinski, however you would care to share your part, from the time someone is injured on the battlefield, what happens to him or her all the way through, so that we know what the plan is, and then we will go into what we all need to be doing while that process is unfolding or to make sure that process is in place.

PROCEDURE FROM BATTLEFIELD TO VA

Dr. HOLSINGER. I would be happy to do that, Madam Chair. Let me just take a minute to lead you into how we get to the place where that individual enters the system. First of all, as you recall, Public Law 97-174 gave the VA the support mission of the contingency backup to the Department of Defense.

Under that legislation and a memorandum of understanding between the VA and DOD, the Secretary of Defense will notify the VA when he needs the contingency plan activated and the system put in place.

That relationship is between myself and Dr. Enrique Mendez, the Assistant Secretary of Defense for Health Affairs. The Secretary will set the priorities for DOD casualties. That has been set in our plan. We will serve service-connected veterans and individuals who are not service connected requiring emergency care on a first-priority basis, and then we will be taking care of all returning casualties.

All other nonservice-connected veterans will come in priority, after the returning service men and women who might be casualties. The Secretary will notify me that the system is in place. That

information will go throughout our system to our medical centers and they will activate their contingency plans, and the VA/DOD contingency hospital system will be in place.

Our command center in central office and our emergency operation center in Martinsburg will become operational 24 hours a day, and we will begin the actual bed reporting availability on a 24-hour and on a 72-hour basis to the Armed Services Medical Regulating Office [ASMRO] at Scott Air Force Base in Missouri. They have the responsibility for making the decision as to which beds the patients end up being transferred to, either military or VA.

Our medical centers have made arrangements to receive patients at their arrival sites and to transport them to the VA. We have a full range of clinical and support services, provided they are available, either on station in our facilities or by various sharing agreements with the university medical school hospitals across the country or by contract.

We will receive 12 to 16 hours advanced notice prior to patients being received at the arrival site. This is why the 72-hour bed data is important to ASMRO, in that they need the data in order to be able to regulate patients to us as they come out of Saudi Arabia or the Persian Gulf area. It takes a period of time, not only for flying time, but also to make sure the individual is stable and the beds are available.

We will be developing the appropriate recordkeeping to track these military patients, as far as working with military patient administration teams in our facilities, and in relationship to the supported DOD facility.

PATIENT TRACKING SYSTEM

We will also be providing a patient tracking system for family members and interested individuals at our Huntington, WV, facility where we have an 800 number with 20 lines that will be manned and available to act as a locator system for individuals desiring to know where an individual might be in a VA medical center. We will at least have available the basic information as to the individual's current condition.

Once individuals are discharged back to DOD, of course, they are out of our control and back to theirs. If they are medically discharged because they have severe enough war injuries to prevent their return to duty, they become a service-connected veteran at that point in time and we have responsibility for them. As service-connected veterans, they then become our highest priority, under Public Law 97-174.

If I may, I will utilize the chart that we have brought because I think it will help to make the flow make more sense.

Senator MIKULSKI. I can't see back there? Can you see it?

Dr. HOLSINGER. This is the overseas theater of operations. As the individual is returning from overseas into one of our hub airports that have been designated jointly with Military Airlift Command, ASMRO, the Armed Services Medical Regulating Office, makes the determination where that returning individual will be taken care of. They regulate, if you will, a patient to a bed.

The MAC, Military Airlift Command, is actually doing the flying of the patient, bringing them back out of the theater of operations. Their headquarters is at Scott Air Force Base where ASMRO is located, and they make the decision as they bring them out of the theater, whether they go to a hub or a spoke facility.

Now, we have set up our system in conjunction with the Military Airlift Command so that we have a whole series of hubs with a hub hospital with spoke airports that serve that hospital.

HEALTH CARE TREATMENT PROCESS

Senator MIKULSKI. Let us just stop for a minute. If I could just ask you some questions. As I understand it, this is really meant to be a plan that was a model of frugality and resourcefulness, that in time of peace, rather than maintaining an enormous capacity in military hospitals, what we did was essentially have our basic infrastructure to meet regular military needs so that we have our military hospitals.

But now as we mobilize, what we have is the capacity at the military hospitals. Then we trigger the capacity that we have in our VA hospitals, and then also we would have the ability to tie into trauma and specialized medical systems that are serving the civilian population.

So that essentially in peacetime, we have the Veterans Administration and civilian hospitals that are serving their civilian and peacetime population, but now in the event of this emergency all of that can be mobilized without being nationalized; am I correct?

Dr. HOLSINGER. You are correct.

Senator MIKULSKI. So now let me get it, because then I want to go to what happens to the redirected and possibly even the turnaways. If someone is injured on the battlefield, they will immediately be treated in trauma battle centers or out on the hospital ships like the U.S.S. *Comfort* out of Baltimore, our kind of shock trauma of the seas.

They will be treated there. Then they will also go to the military hospitals in Western Europe. Is that correct, like Weisbaden?

Dr. HOLSINGER. They may or may not go by way of Europe.

Senator MIKULSKI. They will be treated on the battlefield and then some will be going to Europe and some will then be coming back here?

Dr. HOLSINGER. Correct. In the theater of operations, the Armed Forces will have an evacuation policy, let us say it is 15 days. That means if an individual can be returned to duty with his unit within 15 days they will be treated within the theater of operations.

If they cannot be returned to duty within that 15-day period, they will be evacuated out and will either come back to the United States or to Western Europe. It depends upon what the situation might be.

Senator MIKULSKI. OK, so then they will be coming back. You are notified, and then all of these various military communication mechanisms go into place. Now, as I understand it, when they come into a hub, which hub will they come into? Is there like hub 1 and when that fills up, you go to hub 2, and then when that fills

up, you go to hub 3? Or do you go to hub 1, 2, and 3 simultaneously?

Dr. HOLSINGER. A lot depends on one, the number of casualties; and two, on the flow coming back. Specifically, ASMRO will make the determination. If there is a capability of beds near the individual's home, if you will, the military base from which they left to go to Saudi Arabia, they will attempt to get them back into a general hub area that is relatively close.

We originally started out with a smaller group of hospitals that would be receiving casualties, but as we have worked with MAC over the last 3 or 4 months, that has developed into an 80-bed priority receiving hospital system with a series of hubs with spoke arrangements that allow us to get that individual to a bed by MAC airlift flight.

TRAUMA CASES TO THE VA

Senator MIKULSKI. I am going to ask you or Mr. Derwinski two kind of questions relating to this very ingenuous plan. There are those in trauma medicine who say, first, why go to VA? That once your military hospitals reach their capacity—and this is not my view necessarily, but the question needs to be asked—why not take them directly into the trauma centers which are usually based in each State.

They have high-technology equipment, the most modern. They have staffs there that are used to dealing with trauma at various stages and, therefore, use VA only as kind of rehab, followup and perhaps for psychiatric illness. What would you say about that or is that under consideration? Are they valid points?

Dr. HOLSINGER. I think it is an interesting point, but not necessarily valid. The 80 primary receiving hospitals are almost entirely teaching hospitals, tertiary care referral, treatment hospitals that are closely affiliated with a major U.S. medical school. As a result, we have in those hospitals that we are using for our primary receiving hospitals individuals who are on the staff of those hospitals or on the faculty of the medical school. In fact, they are often part-time in both places.

So we bring into play immediately the entire set of skills of the trauma surgeons; for example, at our affiliated medical schools. People have often wondered what these sharing arrangements between our VA and medical schools are good for. This is a prime example. With the assistance of our affiliates, we will be able to rapidly increase medical capability in a surge type of way, bringing in our consultants and attendings from the university hospitals to help with this type of care.

Senator MIKULSKI. So we will have the best of the trauma personnel?

Dr. HOLSINGER. Without doubt.

SPECIALIZED INJURIES

Senator MIKULSKI. Then as I understand it, for specialized injuries—spinal cord, burns—that we will then be contracting with individual facilities?

Dr. HOLSINGER. In the case of burns, they are obviously an interesting situation because there are a very limited number of burn beds in the United States, period. The VA has a very small number. The military has the National Burn Center at Brooke Army Medical Center.

But for severe burns we will need to use community resources, and that is being tracked constantly in this process.

Senator MIKULSKI. For example, in Baltimore, where we have the burn unit tied in with our trauma medical system, that would be a specialized area that would see those kinds of injuries.

Dr. HOLSINGER. That would be correct. In the case of spinal cord injuries, we would anticipate that our acute spinal cord injury units across the VA would be able to handle the spinal cord injury patients. Under a memorandum of understanding with DOD, the VA has been handling all spinal cord injury patients on active duty for decades now because individuals historically, who have spinal cord injuries will be boarded out of the service and become service-connected veterans.

So we provide that kind of care within our system for the entire Federal military services.

VA CAPACITY

Senator MIKULSKI. I have one more question before I turn to my colleague, Senator Bond. My question then says, OK, we have this integrated system, but for years the Veterans Administration has been meeting a veterans' population. It has faced the most stringent of budget constraints over the last decade, something we are trying to restore.

Will this Operation Desert Shield, the call to meet our casualties, as well as our veterans, essentially paralyze the VA by overwhelming it with the need to meet this because the capacity already at Veterans Administration was under some strain?

This is one of the questions many Senators have raised in the most concerned way. So if you are going to be strained, if not a failure—we do not view that as a failure of the VA to want to do it, but because of the already strained and sometimes skimpy resources that have been provided to the VA to meet their normal mission.

Doctor? Mr. Derwinski?

Dr. HOLSINGER. Senator, I think that particular issue is one that many people do not understand. The system would work from a different perspective once we institute the VA/DOD contingency hospital system—new priorities come into play.

That is, that service-connected veterans have first priority. We will treat all veterans requiring emergency care, but we will defer nonemergent, nonservice-connected care until after we get past the initial bolus of care for our returning casualties from the contingency that we have planned for, in this case, the Persian Gulf.

So we would have a number of nonemergent, nonservice-connected veterans for whom we would defer care until such time as we get past the immediate bolus of taking care of the injured individuals coming back from the theater of operations.

Now, if during that period the individual has had to be deferred, as we are tracking them in our system, if you will, on a waiting list, if their need becomes more urgent, we will either obtain that care for them in the private sector or we will bring them in, if it is required, into our facility. This all becomes driven by the number of casualties, which is anyone's guess.

LOCAL VA MEDICAL CENTERS

Senator MIKULSKI. Well, hopefully, we will have 150 or less. God be with us.

I think the questions related to the redirected vet and perhaps even some of the deferred or turnaways I will save to my second round, and I want to talk about how it would work specifically in the local centers, using San Antonio and Baltimore as the models.

Senator BOND. Thank you, Madam Chair. There are several questions that our ranking member, Senator Garn, would like to explore. He believes, quite properly I think, that certainly the first focus of the VA should be delivering the finest care and assistance possible for those who are injured or wounded in military service.

It is extremely important considering the current activities in the Persian Gulf and the potential for a large number of casualties as you indicated, Doctor, that we are focusing the role of the Department in assisting those who have borne the battle. Perhaps this first question will get a little bit into the discussion and may have some impact on the subject we are discussing.

Senator Garn would ask that even though the potential budgetary impact of the war is not an issue to be covered in this hearing, we ought to get a better understanding of the arrangements between the VA and DOD as to which agency is responsible for the costs of providing service to those requiring medical attention as a result of wartime casualties.

Could you detail for us the financial arrangements between the two departments as to how such costs would be shared, Mr. Secretary, or whoever you designate?

VA BILLING PROCEDURES

Secretary DERWINSKI. Basically, Senator, the law provides that we will bill the DOD, but Mr. Carroll will go through the precise legal situation which applies to the care and service and reimbursement that we would be receiving from DOD to the point where the person would be discharged.

Presumably then, if this combat-injured serviceman is discharged because of the combat injury, they would at that point be receiving VA medical care as a service-related disability. But I will yield to Mr. Carroll for the explanation of the legal reimbursement process.

Mr. CARROLL. That is correct, Senator Bond. The reimbursement process would work pursuant to a 1986 VHS&RA/DOD agreement which provides for reimbursement at the interagency reimbursement rates and also provides that the funds that are reimbursed will go to the hospital that provides the care. So the hospital that expended the resources in the care of a casualty will get the money back.

However, these interagency rates do not cover transportation and prosthetics. We do have an agreement with DOD that provides for DOD to reimburse the VA for those two services at our actual cost. That is essentially how that service system works.

Senator MIKULSKI. Could you repeat that and pull your microphone closer? There is a lot of buzzing in the room and I missed it.

Mr. CARROLL. Yes, Madam Chair.

In its entirety, we have a 1986 VHS&RA/DOD sharing agreement, which provides for VA to be reimbursed at the Government interagency reimbursement rates. Interagency rates do not cover the cost of transportation and prosthetics.

The agreement with DOD in that case requires DOD to reimburse the VA at our actual cost for providing transportation and prosthetics. The law provides that the VA hospital that incurs the costs for caring for a casualty will get credit for the reimbursements from DOD.

Senator BOND. So, in essence, the bulk of the costs are going to be charged back by the VA to DOD.

Senator MIKULSKI. Could I ask if that would present a cash-flow problem? The Senator really is on a very important line of questioning because you will be laying out the money both at the headquarters and centers like Baltimore, San Antonio, and the others.

Dr. HOLSINGER. I think there are two things here. One is that there is the potential of cash-flow problems deep in the fourth quarter of the fiscal year for obvious reasons. But if we are dealing with something now, we have the authority to be able to move fourth-quarter funds into the current quarter in order to make sure our medical centers are able to have the funds they need to buy what they need pending the reimbursement.

But you also need to understand that Public Law 97-174 included VA and DOD sharing legislation. We have had sharing agreements with DOD facilities for years now, and that is the situation where once again if Baltimore does something for the military, they bill the military. They get the money back, and that is why the sharing activities were able to go up markedly after the 1982 legislation was passed, the same legislation that sets up the contingency mission.

So the kinds of mechanisms that we would use in this situation are long since in place and are being used every day as we take care of things under existing sharing agreements.

Senator BOND. Well, in effect, if a particular hospital had a very heavy load of Persian Gulf casualties and deferred all other activities, it could be that that particular facility would not be drawing down its normal operating costs because the expenses which are provided for in the normal appropriations to the VA would be deferred as you handled the high priority, immediate conflict casualties.

Thus, you would be in the opposite position in some instances where you have had to defer care and, therefore, you have not incurred the costs that would normally be associated with it.

Dr. HOLSINGER. If I could follow up on that. In speaking with the Assistant Secretary for Health Affairs from DOD on this issue, it is anticipated that individuals who will not return to duty will in all

likelihood be boarded out of the service in less than 30 days and thereby become a service-connected veteran.

If you take an individual, for example, who might be a single- or double-lower limb amputee, we would not in all likelihood have fitted that individual for a prosthetic limb by that point in time. As a consequence, the heavy expense of the prosthetics would obviously fall against our budget because the individual would be a service-connected veteran. Likewise, there may be some increase in costs for us if we have to take care of individuals in the community and have to pay community rates for their care.

But you are essentially correct.

Senator BOND. So, if a person with severe wounds or any patient is discharged while in a VA hospital, at that point the care for that patient moves from the DOD budget to the VA budget, and it is the discharge that determines the agency responsible for payment.

Dr. HOLSINGER. That is correct.

Senator BOND. If on Monday that individual is in the service and the discharge papers come through 8 a.m. on Tuesday morning, as far as that individual is concerned, the same people are giving the care. There is no interruption in the care. It just becomes a different account to which that service is billed.

CONTINUITY OF CARE

Dr. HOLSINGER. Senator Bond, you have made an excellent point because I think one of the absolutely key points of the VA-DOD contingency hospital system and our obtaining the care of the patients early during a conflict rather than our more usual situation of starting after the troops come home is the issue of continuity of patient care.

One of the things we think that we can do with this sort of arrangement, by being able to perform the definitive final surgery—for example, on a stump for an amputation—is that we can markedly shorten the period of rehabilitation and have that individual back home at maximum capability sooner than we would have done things in the past.

Senator BOND. Doctor, that is very informative, and I thank you, Madam Chair.

VA READINESS AND PREPAREDNESS

Senator MIKULSKI. Returning now, and, Senator, those were excellent questions. I also want to note that Senator Garn wanted to be here. He was returning from Utah and flights and all made it difficult for him to be here.

I want to come back to the plan itself and how it relates to the individual centers which are of course the crucial part.

Mr. Derwinski, I noted in your testimony that you said that 80 centers will be primary out of the 147 VA medical centers, 80 of them will be designated backups to the military hospitals.

Secretary DERWINSKI. They will be the primary.

Senator MIKULSKI. Excuse me, primary. This then goes to the readiness and preparedness of 80 centers. Obviously, the plan itself is very clear, but its operational aspects are yet to be tested.

Let me get to my question. You have got 80 medical centers and various other facilities; how have you insured that each medical center, all 80 of the designated primary ones, are essentially ready? Have you done specific center by center inventories? Have they submitted individual plans? Are these plans uniform? Have you done drills?

Secretary DERWINSKI. Let me just start by saying that this is something that has had the most intensive direction from Dr. Holsinger these last 5½ months. As he indicated earlier, and correct me if I am wrong, Dr. Holsinger, all of these 80 centers have tie-ins to medical schools where there are both the staff and the support hospital of the medical school available. In addition to that, an intensive analysis of each of these hospitals has been conducted by Dr. Holsinger's staff and by our inspector general to determine that, in fact, they have the beds ready as indicated, and that they are prepared to function.

I think one of the purposes of this hearing and the reason we are interested in cooperating with you and laying this on the record is that we feel we are ready and we will be able to absorb the flow of casualties that, hopefully, will be in the very small number that you hoped for also. But Dr. Holsinger has laid it out. He is the master of the plan.

Dr. HOLSINGER. Well, the answer to all your questions is yes, Madam Chair.

Each of our facilities has developed its own plan. Those plans have been ongoing over the past 6 to 7 years after we entered into the memorandum of understanding following the legislation. They have been iterative in that we have continued to upgrade them, work on them, and so on, particularly during the last 5 months.

It has taken on an entirely different cast from being the potential someday kind of a situation to one that is very real. So our people, I think, and you can speak with both Ms. Gallagher and Mr. Coronado, but I think you would find that at the field level the morale is high. They are ready to go.

Thus, all of a sudden, for the first time in VA history, we have become involved if we are needed in the war, during the war, not after the war. As a result of that, our people have been working hard to be prepared to carry out their part. In addition, we have drilled; our hospitals have drilled; Baltimore drills quarterly.

For example, I know that just a week ago Friday, the VA medical center in Richmond was having a drill at the Richmond International Airport to make sure that their disaster medical assistance teams were able to handle the triage capability and so on. The inspector general also was looking at the medical center's drill.

We have been through a number of drills this past year due to the New Madrid fault earthquake scenario. There was to be a national disaster medical system nationwide drill. That was canceled as a nationwide drill due to some funding problems, but the VA went ahead and conducted our part of that drill which included 25 hospitals in that general area for a 5-day period.

Then the Minneapolis VA Medical Center continued on with their drill for a 30-day period to test plans, our capabilities and so on. The testing of the plans is the responsibility of our VA medical

center directors, and I would certainly ask either of them to comment.

Senator MIKULSKI. I am going to turn to both Ms. Gallagher and Mr. Coronado in a minute. But as I understand it, only 25 of those 80 centers have done live drills. In other words, the kinds of things that I know that they have done in Baltimore, the rest have been somewhat paper drills. Is that so?

Dr. HOLSINGER. I was just checking with Dr. Bonnabeau who is the Director of our Preparedness Office, and in the issue that you are talking about which was during the New Madrid fault exercise, 25 stations did a specific test with patients, triage and so on. The rest of those stations, since lack of funding canceled the national disaster medical systems nationwide exercise, did a paper exercise.

But to say that they have not done exercising I think would not be the case because I do not think that Baltimore was one of the 25 that was involved in the New Madrid exercise.

BED AVAILABILITY

Senator MIKULSKI. We will come back to that because we find that drills are so tremendously important. You do not try it out on the first day that you need it. I would like to go to the bed reporting for a minute and see what the issues have been there and what improvements have been made in reviewing the inspector general's report.

Please understand this is a no-fault conversation. It is to identify where there might be loopholes or potholes or whatever both in the plan and in the fiscal resources in these first quarters to meet the plan. So where there are problems, do not be shy about identifying them. You are not going to be grilled; you are not going to be hazed.

We are really here working in a bipartisan partnership with the administration. Now, the beds. We understand that in the first kind of reporting system that you have the ASMRO, the PAC and MAC and all of that, that beds were not being reported properly so that one hospital reported that it had 500 beds ready to go, and that was pretty much their total capacity.

But when you got down to actual staffing, it was 131. So we want to know, one, has that been improved? And No. 2, would you please tell for the subcommittee what is a bed? Because I think there is confusion in the minds of Senators not familiar with health care. They think a bed is a bed rather than a bed and lots of other things. So if you could, one, tell us about the issues that are important so that we know what we know is really right, and No. 2, really what does a bed mean?

Also, explain the concept of the cost around a bed.

Dr. HOLSINGER. Madam Chair, the situation is this. We have been going through an iterative process of developing our bed availability reporting mechanism. Up until about a week ago, it was a manual system. To come up with the report requires the facility director to determine how many beds are available today. Those are usually the difference between about 80-percent occupancy and the number of patients that they have in the hospital that day.

Then they project their 72-hour beds based upon the nursing staff looking at each patient in the hospital to determine whether that individual will be, in all likelihood, discharged normally within the next 3 days or could be moved to another facility. That is the way the bed projections are developed.

Those reports, in the past, came into our Martinsburg facility where they were re-entered into the computer system, and it was through this process that we were concerned that we would have the potential for bed errors. The inspector general, when they looked at that, did indeed determine that in some instances we had errors in the bed counting. Those occurred usually in the 24-hour bed numbers as in the case of the hospital you are alluding to plus at least one other.

In the case of the hospital that you are talking about, the numbers were accurate at the 72-hour mark, which is the point that ASMRO would be looking at once we began feeding the information to them. During the last 3 to 4 weeks, we have been working diligently to convert to an automated system which would allow the station, the hospital directors' people, to input the number of beds and that would be printed out both with us in the central office and at Martinsburg.

In point of fact, the new system is now up and operational. I have with me the last 2 days' bed availability reports. They do change on a day-to-day basis because even as we are here in this hearing VA patients are being discharged from VA medical centers and other veterans are being admitted to VA medical centers. They may not match.

We believe this system is up and is working and functioning normally now. We have had 5 or 6 days' worth of experience with our automated system.

BED AVAILABILITY—IG

Senator MIKULSKI. I wonder if the VA inspector general or the VA medical inspector general has anything they want to add to that?

Secretary DERWINSKI. We have the inspector general and the medical inspector general here.

Senator MIKULSKI. Gentlemen, I do not know if you had anything to add. We would, by the way, like to thank you for the excellent report. It was very insightful to the subcommittee, and I know also to the authorizing committee because it was at the request of Senator Cranston and his ranking minority to have that report.

Mr. TRODDEN. Thank you, Madam Chair. I am Steve Trodden, inspector general of the Department of Veterans Affairs, and behind me is Dr. Lou Mantel, the medical inspector who works for Dr. Holsinger.

I have not much to add; Dr. Holsinger's description of our report was an accurate presentation, Madam Chair. We did do a very rapid spot check in a 5-day period of some of the data that would have come out of Martinsburg had the bell been rung and Martinsburg asked for information.

We did find errors as you described. They were largely clerical errors. I am not diminishing their importance because had bum in-

formation been reported to DOD it would have been significant. Fortunately, it was not reported to DOD. As Dr. Holsinger has explained, simultaneous with our review of the reporting system, his organization was developing a real time system which, at the time of my report, we had not had the opportunity to check, but subsequently, we have. It does appear the kinds of problems we had identified have been addressed and corrected. As an example, one of those is simply the convention of whether a 72-hour number is additive to the 24-hour number or cumulative.

Senator MIKULSKI. Well, that is crucial because if this had been triggered as we had feared early in terms of the number of casualties, the bum information, the difference between knowing whether a hospital has 100 beds or 500 beds would have truly paralyzed it if these wounded would have been coming to that hospital that only had 25 percent of the capacity to absorb them that they said they had.

Mr. TRODDEN. Correct, Madam Chair.

Senator MIKULSKI. Now, Mr. Inspector General, do you have confidence now that the reporting system corrections have been made and are in place and operational?

Mr. TRODDEN. I will not give the Chair a total assurance because as Dr. Holsinger has said, each one of these estimates at root is a daily updated judgmental statement from a local center.

Senator MIKULSKI. It is one thing to be 5 beds off; it is another thing to be 400 beds off.

Mr. TRODDEN. I am confident, Madam Chair, that the kind of drill that we went through to ascertain those errors was a highly productive drill which has raised the level of attention throughout the Department. Not that it needed it, but it did accelerate the level of attention to that problem.

I believe that the sensitivity is such that the bureaucratic errors, if you will, are out of the system. I think it will be a matter of recurring attention both by Dr. Holsinger and his staff, Dr. Mantel and his staff, and my staff to do periodic checks to make sure those numbers do represent the judgment of the center director.

Senator MIKULSKI. Well, I have a great deal of confidence in the inspector general's system, and I know they bring a tremendous amount of experience, both management, accounting, and auditing. Those tools I think are crucial to this, and we are really very pleased that there is this relationship.

It is kind of like a little independent agency within the agency helping us keep on track. I would like to thank you for the contribution you already made. We know that we will be holding subsequent hearings on it.

CHAIR VISIT TO MARTINSBURG

Secretary DERWINSKI. Madam Chair, I would invite you and the other members of your subcommittee or your staff to visit Martinsburg.

Senator MIKULSKI. We are going to go up there.

Secretary DERWINSKI. I was up there Sunday morning. My diabolical mind told me that over a 3-day holiday things might be a little slack.

Senator MIKULSKI. I think it is a Polish-American mind. We think the same way. It is called, keep them on their toes.

Secretary DERWINSKI. I went out there Sunday morning unannounced, and I was very pleasantly surprised to find that the command center was very effectively manned. They had the reports up to date and they were preparing to take an afternoon bed check across the system.

It is there, and I would invite you to go out there on a spot-check basis and see what they have.

Senator MIKULSKI. Well, actually, I intend to go to Walter Reed and Martinsburg as well.

Senator BOND. Thank you, Madam Chair. Obviously, there are a number of very major financial questions that we cannot even ask yet until we know what the degree of usage will be.

I want to commend you, Mr. Secretary, and Dr. Holsinger for having a preparedness drill on the New Madrid fault situation. While it is off the subject of this hearing, I can tell you having visited New Madrid and studied the potential impact of the earthquakes that hit in 1811 and 1812, and according to anthropologists about 500 years earlier in the 1300's, the potential for that degree of an earthquake given modern construction, high-rise apartments, houses, and office buildings, could require all the resources of the VA along with other hospitals.

We only hope that the fault is on a 500-year schedule which would put it off to 2300, by which time we may have appropriate earthquake standards in place. But, I would like to ask just a couple of specific questions. No. 1, Mr. Secretary, there has been a lot of discussion of the potential for different kinds of injuries that might occur in a conflict with Iraq. Have you had any problems? Are you prepared for contingencies of different kinds of war injuries that might come out of this particular conflict in the Persian Gulf?

MEDICAL SCHOOL SUPPORT

Secretary DERWINSKI. I have been assured that we are. I think I would bring Dr. Holsinger back for any specific questions you have as to the precise area of injury or treatment. But I think underlying our entire plan is this very effective relationship with medical schools. Almost every medical school has an area of specialty that they wish to feature in which we can share under our various agreements with them.

So that has all gone into the selection of our primary centers. I think from my vantage point stepping away from the medical experts but looking at the overall plan they worked out, I think we have very effectively utilized our facilities and their relationship to pockets of expertise in the medical education world.

Mr. TRODDEN. I would yield to Dr. Holsinger.

Senator BOND. I would be anxious to hear if there are any particular comments or problems, Doctor, that you have encountered in those preparations.

Dr. HOLSINGER. I think, Senator, that one of the most impressive things to me has been the support that we are getting from across the American medical community. I have met with a key group of

deans of American medical colleges and schools just within the last 30 days.

They are extremely supportive, have indicated that when it comes to physician needs that we might need in our primary receiving hospitals that are affiliated with their institutions, that they will be in there with us shoulder to shoulder. I received a letter, for example, from the American Academy of Ophthalmology, offering ophthalmologists to assist us on a nonreimbursable basis.

For example, I know that in many States—for example, Virginia—the board of medicine has gone out asking for physicians to indicate their availability to volunteer to be of assistance in caring for returning casualties should they occur. We stand in a unique position in the Federal health services in that we have very close and tight sharing arrangements with the DOD services—Army, Navy, and Air Force.

But we, likewise, have very close sharing activities with America's medical schools, and their affiliated university hospitals which puts us kind of in a middleman role allowing us to utilize a number of beds in the community without having the national disaster medical system actually being put in play. That expands rather remarkably the contingency activity that is available to the Federal Government as we deal with this type of a situation.

TREATMENT OF IRAQI PRISONERS

Senator BOND. My next question may sound a bit strange, but with the potential, Mr. Secretary, for significant injuries of Iraqi prisoners of war with the kind of warfare we are conducting, if we capture a large number of enemy soldiers who are severely injured, it is possible that those prisoner-of-war injured could overwhelm the battlefield sites.

Are there any plans in place to provide treatment in this country for prisoners of war who may have suffered serious injuries and be beyond the treatment capacities of the field facilities in the Middle East?

Dr. HOLSINGER. Senator, the VA, under the terms of our legal mandates, is not authorized to provide that kind of care. I suspect, though, that should such individuals be brought to the United States for care, that the community facilities across the country would be able to handle that and would do so.

Senator BOND. So DOD would work directly with other facilities? It would not impact the VA system?

Dr. HOLSINGER. Well, the impact on us may well be that we would utilize our contacts and our ability to work within the community in order to help to expedite that kind of assistance to DOD. We certainly have outstanding contacts between our VA medical center directors and their counterparts in private hospitals and at the university, and we would be able to broker that care for DOD.

Senator MIKULSKI. Just to be sure I understand your answer to Senator Bond, because he raises an issue which is really quite interesting, and we would do for them what they are obviously not doing for us.

Senator BOND. I think that, Madam Chair, is the difference between us.

Senator MIKULSKI. Absolutely, but what you are saying is—should it be that significant of a number that they were not treated in the battlefield and then placed in other facilities nearby the theater of operations, they would not be treated at VA hospitals; is that correct?

Dr. HOLSINGER. That is correct. I would anticipate we would have to seek a legal mandate to do that.

Senator MIKULSKI. We are not advocating; we are just trying to get a picture.

Mr. CARROLL. That is correct, Madam Chair. Right now, all the authority we have is pursuant to statute, and the statute does not provide for authority to treat any non-U.S. citizen.

Dr. HOLSINGER. We can treat certain allied casualties under certain conditions, but they are very tightly spelled out in law, and we are very mindful of those, so the answer to your question is no, we would not treat Iraqi prisoners of war within the VA medical centers.

Senator MIKULSKI. No current veteran would be displaced?

Dr. HOLSINGER. That is absolutely correct.

Secretary DERWINSKI. Madam Chair, on that point, I would like to give you an example, I think, of how we would approach it. We have had numerous requests over the years from private groups, quasi-government groups, to treat Soviet veterans, and the response we have given in each case is that if we were fully compensated, if we had space available, and if no American veteran would either be displaced or have to remain on a waiting list for service we could treat Soviet veterans. By the time we laid out our conditions, we did not receive any takers.

Senator MIKULSKI. Well, those are very good conditions.

Senator BOND. You say there are provisions for treating allied casualties. Under what circumstance, and how would that be reimbursed?

Dr. HOLSINGER. Those are allied casualties, usually under World War II legislation, if I remember correctly. It has normally been some British. We certainly are involved with funding Filipino World War II veterans who were veterans of the United States Army at that time, and so on, and we have some legislation that allows us, I believe, to handle Canadians.

[The information follows:]

VA AUTHORITY TO CARE FOR INJURED MILITARY PERSONNEL OF COUNTRIES ALLIED WITH THE UNITED STATES IN THE MIDDLE EAST CONFLICT

Generally, VA medical facilities may only care for veterans of the United States military. There are, however, a number of exceptions to this general rule, some of which may authorize VA to provide care to military personnel fighting alongside the United States in the Middle East conflict.

VA has authority to provide medical care to discharged military members of nations allied or associated with the United States in World War I (except any nation which was an enemy of the United States during World War II), or in World War II. 38 U.S.C. § 109(a)(1). Such care may only be provided under an agreement by which the other nation provides reciprocal services to United States veterans and agrees to reimburse VA in cash for expenses. Id. VA may provide this care either in VA facilities if there are beds surplus to United States veterans' needs or in contract facilities. Id. § 109(a)(1)–(2). Under this authority, therefore, VA could provide care to

discharged members of the British and Canadian but not the Italian military under a reciprocal agreement.

In addition, VA could provide care to casualties of countries allied with us in the current conflict under an agreement with DOD or another Federal Government agency to provide care as directed by that agency. If, for example, DOD has authority to provide medical care to allied soldiers, it could contract with VA to provide such care. VA would have authority under the Economy Act, 31 U.S.C. § 1535, or under the VA/DOD sharing authority, 38 U.S.C. § 5011, to enter into such an agreement. We note, however, that the VA/DOD sharing authority only permits VA to provide care if it would not adversely affect the care of veterans. 38 U.S.C. § 5011(d)(3). In addition, both authorities would require the other Federal agency to reimburse VA for the care provided: Section 5011(d) permits VA and DOD facility directors to negotiate the rates in accordance with VA/DOD guidelines; section 1535(b) requires that the providing agency be reimbursed on the basis of the actual cost of the services provided.

Finally, VA could provide care to allied casualties under 22 U.S.C. § 2357(a). That statute provides:

> Whenever the President determines it to be consistent with and in furtherance of the purposes of subchapter I of this chapter and within the limitations of this chapter, any agency of the United States Government is authorized to furnish services and commodities on an advance-of-funds or reimbursement basis to friendly countries. * * * Such advances or reimbursements may be credited to the currently applicable appropriation account, or fund of the agency concerned and shall be available for the purposes for which such appropriation, account, or fund is authorized to be used under certain circumstances set forth.

The President's authority under this provision has been delegated to the Director of the United States International Development Cooperation Agency in consultation with the Secretary of State. Exec. Order No. 12,163, 44 Fed. Reg. 56,673 (1978). Attached are a VA General Counsel Opinion and a Department of State Memorandum which indicate that VA may have provided care to South Korean veterans under this authority in the late 1970's.

Senator MIKULSKI. Just a comment, going back to Senator Bond's question. The war is primarily an American war, with backup of some crucial allies like the Brits, and so on, for which I think we are all appreciative. If there is the burden of Iraqi POW's, it is this Senator's opinion that Western European allies in other countries that have made skimpy contributions to the effort could make their civilian facilities available. There should be burden sharing, even if there has been, for a variety of reasons, lack of the ability to share the risk. I certainly know, I think, that West Germany—excuse me, Germany, with its excellent medical facilities, could absorb a good bit of this, and perhaps some of the other European EC92 countries could do that.

Senator BOND. There is bipartisan agreement on that, Madam Chair.

Dr. HOLSINGER. Madam Chair, there are also significant facilities in Saudi Arabia. They have outstanding facilities which have been built during the past decade, so there is the potential for a fair amount of capability for Iraqi POW's being cared for. As I understand it by CNN, the POW's are being held by Saudi Arabia, and if that is the case then I would anticipate that they would try to care for them.

SAN ANTONIO

Senator MIKULSKI. Let us come back home, though, to our own American soldiers. I would like to turn to how this actually works in the field, because that is where the hands-on care will be delivered, and also the cost will be incurred.

I would like to turn first to San Antonio, so Mr. Coronado, if you could tell us from your perspective as the administrator, essentially take us through the answers to some of the questions we asked. Have you drilled? Are you ready? Do you have the capacity? What are your arrangements, and then what are the problems that you might foresee, particularly with the redirected and indigent—medically indigent vets and so forth.

If you could take us through San Antonio, and then Ms. Gallagher, the Baltimore situation, so that we would have a hands-on field view of this.

Mr. CORONADO. Thank you, Madam Chair.

Senator MIKULSKI. We welcome you. I am very familiar with Ms. Gallagher and her work, and now we are going to learn about our Southwest preparedness.

Mr. CORONADO. I bring you greetings from Texas. The Audie L. Murphy Memorial Veterans Hospital based in San Antonio is a tertiary care facility. We have 704 authorized beds and a 120-bed nursing home. Our main affiliation is with the University of Texas Health Science Center at San Antonio, and we service all the veterans in south Texas, which has about one-quarter million veterans.

We have five satellite clinics: San Antonio, Victoria, Corpus Christi, McAllen, and Laredo. We have four vet centers based throughout the area. We service two national cemeteries. We also serve an area that has the highest unemployment rate in the Nation, which is south Texas, and we have great concern for our veterans who live in that area.

At this time, the Audie L. Murphy Memorial Veterans Hospital is prepared to activate the VA-DOD contingency plan on orders from our central office. We were one of the hospitals that was reviewed by the inspector general last week and we were found to be in compliance with all requirements at that time. The only criticism was that we tended to be a little bit conservative in our bed availability numbers as we reported them. We have a spinal cord injury unit which is to come on line this summer and we have numerous sharing agreements with the Department of Defense.

As you well know, the San Antonio area has four military bases. We have two other Federal hospitals—the Air Force's Wilford Hall Air Force Medical Center and the Army's Brooke Army Medical Center at Fort Sam Houston. We operate facilities jointly in some places.

Wilford Hall and VA operate a blood bank that services the military as well as the VA in the area. We provide services for each other in such areas as imaging, the treatment of burn patients, and in working with closed head injuries. During our involvement in the Panama incident, we received two military casualties. We worked rather well with the military.

Our receiving airport is Kelly Air Force Base. That is a supply center for DOD and on their return flights they usually bring casualties to San Antonio, so San Antonio has become an important point for dispersing military casualties. At this point, we have no major concern about resources. Our main concern has to do with the reservists.

San Antonio is essentially a young-staffed hospital; we find that in reviewing our staff that we have 432 members of our staff that

have some form of Reserve obligation. We already have had mobilized 56 individuals, which is 2.6 percent of our staff.

This is over twice the national norm. I think nationally we have experienced about a 1-percent callup. We have 18 more individuals alerted for mobilization. Members assigned to Reserve units who participate in scheduled drills but have not been called are 64.

Senator MIKULSKI. Excuse me, Mr. Coronado, could you tell us the nature of the skills? Are they doctors, nurses, are they computer operators?

Mr. CORONADO. Those mobilized were 3 physicians, 24 nurses, 1 medical resident, 18 allied health, 3 LPN's, and 7 administrative staff. The one specialty that we have great concern about is the registered nurse. They were in short supply to begin with and, with the callup of reservists, we are experiencing a shortage there.

However, we have made arrangements in the community to try to make up for these shortages. We have called upon the local contractors that provide nurses on a fee basis. Our physician staffing has worked well through our affiliated medical school. We have met with the county medical society and they have assured us that were we to get into any difficulties they would muster their resources to be of help to us.

My main concern at this point beyond what I have mentioned is that sometimes we get hit in one department. We have lost the chief and assistant chief in one of the largest administrative services at our hospital, but I think the morale of the staff is so high that we have been able to sustain and reorganize ourselves continuously, and we plan to continue to do that as we move further into the activation phase for the VA-DOD contingency plan.

I would leave you with one concern; that is, the replacement of staff. Right before the problem began in the Middle East, as a result of the budget reconciliation, a provision was passed that permitted individuals to retire to take advantage of the lump sum payment that they had contributed. We lost 33 individuals to that program at the end of November, and soon thereafter we began with the callup of Reserves.

We have been working with the Office of Personnel Management to see if there would be a way of finding an exception by which these individuals could be returned to duty if they would like to come back without penalty to their pension. So far, we have not been able to find that provision.

RE-EMPLOYED ANNUITANTS

Senator MIKULSKI. Mr. Derwinski, the point that Mr. Coronado raises is a very interesting one. During some other problems that occurred, I spoke to Connie Newman, head of OPM, for what we called a waiver, in which people could be called back without penalty who were recently retired—meaning that they had the skills, they had the personal contacts, they had their own Rolodex, all of the things that mean they could come back rather quickly.

It was something we worked on with FEMA and the Hugo mobilization, so there are models in place to deal with these issues, and I think it really will take a Cabinet-level secretary working with OPM to get into that and, of course, we would do all we could to

encourage that. I think that is another pool of people, particularly in communities where there is a significant number of Federal employees.

Is that it?

Mr. CORONADO. That is my statement; yes.

BALTIMORE

Senator MIKULSKI. Ms. Gallagher, first I would like to note that we have been joined by our New England colleague, Senator Leahy.

Ms. Gallagher, do you want to tell us, then, about what you have done in Baltimore, because you have done a drill and civilian-based relationships.

Dr. HOLSINGER. Senator, if I could interrupt just a second, I would like to piggyback on something Mr. Coronado said. As you recall, he indicated that he had received two patients during the Panama campaign. I had failed to mention earlier that behind me is Dr. Lewis Mantel, who is the medical inspector, and prior to his retirement from the U.S. Navy on July 1 he was a rear admiral assigned as deputy director of JCS—J4 of JCS, where my Reserve assignment is, and at the time of the Panama incursion the decision was made to go to San Antonio specifically because Brooke Army Medical Center, Wilford Hall Air Force Medical Center, and the Audie Murphy VA Medical Center were there, and they would give us a backup capability. They were put on alert for the possibility of the contingency system being activated in their case.

Senator MIKULSKI. Ms. Gallagher?

Ms. GALLAGHER. Thank you, Senator. As you know, having visited our hospital last Wednesday, we are indeed prepared for any eventuality which may occur. We have 184 beds in our hospital. At this moment, we are, as you know, in the process of building a new hospital, which will be 324 beds. We have contacted other hospital units in the Baltimore area for backup. We are affiliated with the University of Maryland and with Johns Hopkins. Johns Hopkins is affiliated with us in surgery only. We have made contact with the Francis Scott Key Burn Center, with the Wilmer Eye Clinic, with shock trauma, and with physicians in the area to give us any backup that may be necessary. The hospitals that are working with us have assured us—for instance, shock trauma has said that it will make available any kinds of transportation which may be needed. They certainly have a helicopter pad, as you know, on the top of the University of Maryland Hospital, in case that would be needed, but we are assured that all of those services with our affiliations agreements will be intact.

We also have sent our physicians to the Aberdeen Proving Ground to be trained in taking care of patients who may come back with any kind of chemical warfare injuries. We also have a large infection control section in our hospital that may be activated readily if anything is necessary.

The transportation issues have come up with us as well, and we are ready to be the primary hospital for Walter Reed. If we have to have transportation to go to Baltimore-Washington Airport instead of Andrews, we are ready to do that as well.

Dr. Holsinger spoke about emergency drills. We do emergency drills for casualties every quarter. In fact, when the Chase Railroad collision occurred, we had people from our medical center who were ready to help. We also have a large PTSD component in the psychiatric section in our hospital—posttraumatic stress disorder—and we are doing that now with Vietnam-era veterans, and we have a large psychiatric component.

We are also preparing ourselves to be ready for female veterans. We have an agreement with the University of Maryland in GYN and obstetrics on any female disorders or injuries.

We function now, as you know, in a tertiary care manner. That means that any patient who comes to us can be cared for. We are not a long-term care facility.

We also are ready with our sister hospitals, Fort Howard or Perry Point, in case we have to discharge some of our patients to those facilities. So I think that, in general, we are absolutely ready for whatever may occur. We were visited on Friday by the medical inspector, and I think he found there was a hospital at the ready.

Now there will be glitches; we are all aware of that. But we are ready for eventualities. We tried to stretch our minds to see what would happen if, and that is the way we are functioning today.

A major concern indeed will be nurses. We now have some nurses on contract. We have alerted all of the contracts we have that we may want more nurses. We also have had calls to our volunteer service. We have had 21 or 22 volunteers calling us to say, "What can we do to help?"

Among some of those volunteers are retired nurses. We are working with those nurses. They, of course, will not go on the floors unless they are licensed and have been boarded. But they can help in other ways that are not direct hands-on nursing.

We also are ready to go to public announcements for more nurses. If, in fact, we receive more casualties than we can handle, we will go to our television stations, with whom we have a good relationship, to say we are recruiting and we need more nurses. So I think we are as ready as we can be at this time.

We are being very sensitive to the patients we now have. We want to be sure that those patients do not feel displaced in case casualties come in and that they will have the continuity of care that they have had all along.

We currently work closely with the University of Maryland. For example, if we have to place a patient there for cardiac surgery, we can do that through our affiliation agreements. We would do this in order to maintain continuity of care as new casualties come in.

But I do think, Senator, that we are indeed ready.

Senator MIKULSKI. Well, Ms. Gallagher, you know, I visited the Baltimore facility, and I was very impressed at the way one will liaison with other trauma units.

You raised in our conversations and visit some very interesting issues related to what we would call the redirected veteran, or essentially the veteran that would go into the backup brother/sister facilities.

Also, the concern about some possible turnaways, meaning those veterans that are nonservice connected, for whom they are, what we would call the medically indigent, primarily men who get up

and go to work every day and fall into what we would call the uninsured, the capacity for whom the VA had been their medical safety net.

All the veterans that I have spoken to want to back up the VA and cooperate. But for the people currently getting treatment, could you then outline for us how, using Baltimore as an example, you would do it if you moved—the transportation, who does it? What are the plans? What are the concerns, both about care and compensation? Who pays for what?

Ms. GALLAGHER. I can address the indigent veterans for you. We have great concern about that.

TREATMENT OF INDIGENT VETERANS

Senator MIKULSKI. There are two kinds of indigents: ones that are medically indigent, those who work and who have no health insurance, but they are self-sufficient in every other way.

Ms. GALLAGHER. Right.

Senator MIKULSKI. Then there is the indigent vet, who, for a variety of reasons, is unemployed or whatever. Are they treated the same or are they different? Or can the civilian system pick up on that?

Ms. GALLAGHER. We treat the patient's illness and we do treat the patients who are indigent. I do not know what you mean by "the same," but they get the same care that every other patient gets, if you mean it in that manner.

Senator MIKULSKI. I am sorry; I meant compensation. As you know, for the medically indigent, there is no compensation. If they were being treated at Mercy Hospital in Baltimore, they would fall into the so-called charity or uncompensated care. Then there are the indigent that are Medicaid-eligible, and Mercy or Francis Scott Key would be reimbursed for that.

Ms. GALLAGHER. Right; we would take care of those patients. For some of the patients who do have medical insurance, we would bill the medical carrier for the cost. Those patients who do not have insurance, would not be billed. If a patient were seriously emergent—let us say one of these patients had a heart attack, we would have to screen that patient and see what could be done for him and admit them if necessary.

So each of those patients would be tracked. However, we may send some patients to a private facility or to our sister hospitals for care. We are tracking our patients through our clinics so that, hopefully, no one will fall through the cracks.

PRIORITY OF NONSERVICE CONNECTED

Senator MIKULSKI. Is this one of the issues that, for the nonservice connected—that for veterans with service-connected injuries, they are receiving priority care right along with the casualties?

Ms. GALLAGHER. Right.

Senator MIKULSKI. Then we move to another category of nonservice connected. Very often it could even be the elderly population.

Ms. GALLAGHER. Right.

Senator MIKULSKI. That then becomes a concern about where they go.

Ms. GALLAGHER. That is right, but that is one of the reasons why we are using our backup hospitals very carefully right now. Now, there may be some patients who will not get in. That is a concern. If, let us say, all of our beds got filled with casualties and with service-connected veterans, there would be those patients who would not get in.

Hopefully we will not get to that stage, so at this point in time we are taking care of those patients appropriately and giving them the care they need. If we cannot give it, we would certainly go to our sister hospitals.

Senator MIKULSKI. Doctor, I will come back to you in just a second. What percentage of the acute care that you delivered at Baltimore was to the nonservice-connected veteran population?

Ms. GALLAGHER. I have to say about 70 percent.

Senator MIKULSKI. So this is a significant number of the population.

Ms. GALLAGHER. Of the indigent, yes; really poor people.

Senator MIKULSKI. Doctor, did you want to comment?

Dr. HOLSINGER. I was simply going to say, Madam Chair, that we will provide the care to nonservice-connected veterans with an emergency. If we have the bed available, we will do that within our own facility. If we do not, and they arrive at our facility, we will make sure that they are cared for somewhere within the community or in another VA medical center.

The individuals that we would not be caring for would be nonservice-connected individuals who are not emergencies, and we would simply defer their care, put them on a waiting list, bring them back in once we had gone through the period of time in which we had the casualties cared for.

So much of what we are dealing with is hypothetical because we do not know the number of casualties we might have. If it is a relatively low number, there will probably be essentially no displacement at all of these veterans.

Senator MIKULSKI. Is this plan going to need to be adjusted as it moves along.

Dr. HOLSINGER. That is correct. It also entails using probably at least 14,000 DOD beds as well as our own, so that you begin to get some idea. With the calling up of individual ready reservists, the IRR, that will help to expand the DOD's beds.

Their beds have been limited to about 14,000 for this contingency in the United States simply because of not having the personnel. They may go to 16,000 or 18,000 now, but nonetheless it still entails using all their beds as well as the beds we make available.

Senator MIKULSKI. Ms. Gallagher, did you want to add to that?

Ms. GALLAGHER. No.

Senator MIKULSKI. I am going to come back with issues related to cost and staffing, but I would like to turn now to Senator Leahy, if he has any opening statement, and then of course any questions he might have.

We have had a very good and energetic hearing.

Senator Leahy.

STATEMENT OF SENATOR LEAHY

Senator LEAHY. I know you have. I was briefed earlier by my staff, and I will have a couple of questions for the record. I applaud you, Madam Chair, for having the hearing.

Mr. Secretary, if there was an indication why the Veterans Administration should be at Cabinet level, this is one. We have had a great deal of talk about the logistics of getting our munitions over there; airplane fuel, building new air fields, and all of that. But you have a very difficult job in planning what happens in the following months, and even 10 and 20 and 30 years from now as a result of the war in the Persian Gulf.

I know from discussions we have had that these problems concern you. I am glad you have prepared these plans because I think we are seeing some disruptions within the civilian area as medical personnel are called to duty. I have seen it in Vermont in civilian and VA hospitals.

But that is something we can cope with. I think we have to realize that one of the great and lasting costs, as this war progresses and becomes more extensive, as many now feel it will, will be the added cost of dealing with those who are injured. That puts an enormous burden on you.

If I had any advice at all, it would be, as you present testimony here and as you get more information to us and to the President and OMB, do not understate your needs. I find as I talk to people in Vermont and around the country, whether they are for or against the war in Iraq, the one thing that unites everybody, is support for our men and women who are in the Persian Gulf.

I have heard these feelings from the most passionate peace demonstrators in Vermont and the most avid supporters who say: "Let us go in there and go after Saddam Hussein and run him into the ground." Both sides feel we should not make the mistake that was made in Vietnam—to ignore initially those Vietnam veterans returning home.

So Madam Chair, I appreciate your holding this hearing. The Secretary and I have been friends for a lot of years, and I just want to say, if it does not hurt him back home, to get a compliment from this side of the aisle, Mr. Secretary, I am glad you are there, and I know you are looking at this very carefully.

Secretary DERWINSKI. Senator, we look on this as a very special challenge to the VA. Back in World War II, military medicine was so huge, because the Armed Forces had such a huge military operation. Basically, they took care of the injured. Then after the discharge, the VA in those early postwar years was able to absorb them.

In fact, at this point, as Dr. Holsinger just mentioned, there are about 14,000 beds that the military may have available. So we are essential to the military if there are casualties of a substantial nature.

Without wanting to sound melodramatic about it, this could be our finest hour if we do our job right. That is what we have told our people in the field. That is the point Dr. Holsinger has been stressing. That is why our inspector general has been so helpful to us in helping pinpoint early problems. We had technical problems

in our account. We are ready, willing, and able and determined that we will respond as called upon.

As we do, it is, I think, a tribute to the years of investment that the various administrations and Congress have placed in the VA, and it is our responsibility to serve this new generation of veterans.

Senator LEAHY. Mr. Secretary, if my reading about feelings around the country is correct—and I believe it is, because I have certainly heard so many things from other Senators—there is strong public support for the men and women who are over there. We do have a duty to help them. They have answered the call.

This weekend I watched another group of the Vermont National Guard ship off to the gulf. We have all seen similar ceremonies in other States. Our State is so small that I probably knew one-half the Guardsmen or their families. We deeply feel the callups in a small rural State. I suspect that even in the larger States there is still the same feeling. Every neighborhood knows if somebody is gone from there. This is a time when people want our troops supported. I applaud you for your important planning.

And, Madam Chair, with that, I will leave it in your good and extraordinarily competent hands.

Senator MIKULSKI. Thank you, Mr. Leahy.

PSYCHIATRIC CASUALTIES

I think one of the things, there is a great passion, and there should be a patriotic passion to support the troops, for all of the veterans were once troops. This is why this whole issue of supporting the veterans—there are those, as you know, who wanted to dismantle veterans' and give everybody a voucher and get their health care that way. It is very easy to forget that the veterans we are caring for have fought at Okinawa; they fought at Porkchop Hill, Viet Cong Delta, the streets of Beirut. All of those are veterans.

We should support them as they return from battle as casualties, but then these commitments have to be long term and sustained. This is where the Appropriations Committee comes in. So even as we deal with casualties, these men and women will then be veterans.

Let me go to two issues Ms. Gallagher has raised, which is the issue of psychiatric casualties. Very often we have focused on burns, surgical, or orthopedic issues. Could you tell us, Doctor, what is really the concern around psychiatric casualties?

As I understand from my other briefings, these weapons that could be used against our troops are of such a ghoulish nature that they will have a profound effect on even those who do not bear the immediate wound. Would you comment on that, and then what you anticipate?

Dr. HOLSINGER. I think it is important, Madam Chair, that we recognize that we have in essence mobilized our psychiatric and PTSD operation within our system to be prepared for psychiatric casualties and individuals who might have posttraumatic stress disorder.

There are some fascinating things that have happened as far as the military is concerned, and that is, over the last decade, they

have worked diligently to develop psychiatric teams that are stress management teams that would be far forward on the battlefield of today's battle. As a result of that, we have high hopes that we will have a smaller percentage of individuals who might return from the Persian Gulf conflict with posttraumatic stress disorder than we might have otherwise.

I think that, in the case of the Amtrak derailment in Maryland, having stress management teams on the site at the time working through that problem, helped to demonstrate the remarkable nature of what can be done with human beings when you actually deal with the stress at the time rather than months or years later.

In an effort to get ready for that, we are prepared to detail our individuals that are PTSD experts from our vet centers and into our hospitals in order to deal with returning casualties. We also will work to maintain a continuity of care of our patients from the vet centers that have been getting PTSD services there, either at the vet center or at the facility.

But we have a significant number of individuals in both our hospitals and in our vet centers who are really experts in PTSD and deal with these issues on a daily basis. We are going to maximize the capabilities of our people at the hospital in order to do that.

We also have, as you know, a number of PTSD contracts around the country that are already in place and are caring for some of our patients, a small number. We have the ability, therefore, because of those contracts being in place, to expand the number of patients that they care for under contract, whether that be veterans who are currently receiving PTSD assistance through our vet centers, or whether it might be individuals who are returning casualties. So we are moving to maximize our efforts through our vet centers as well as our hospitals to make sure that we are prepared to care for our returning psychiatric casualties.

Senator MIKULSKI. Will you be using a variety of personnel, not only the trained psychiatrist, but the psychiatric nurse and the psychiatric social worker?

Dr. HOLSINGER. Absolutely.

Senator MIKULSKI. Of which there is a larger civilian pool to draw upon?

Dr. HOLSINGER. You are absolutely correct. Our approach to treating PTSD and psychiatric diseases itself, is to utilize a team approach, which is made up of not only psychiatrists, but psychologists, psychiatric social workers, psychiatric nurse specialists, as well as rehab counselors. So we will be using a multidisciplinary team approach to care for any such patients.

Senator MIKULSKI. Did you want to comment, Ms. Gallagher?

NONSERVICE-CONNECTED VETERANS

Ms. GALLAGHER. No; I think Dr. Holsinger has indeed expressed what is going on at the field facilities in psychiatry and posttraumatic stress.

I do want to make a correction. I think I said 70 percent when I mentioned the nonservice-connected indigent. It was 17 percent. I am sorry. I just want to correct that for the record. It makes a big difference.

Senator MIKULSKI. It sounds like the bed count you had there.

Ms. GALLAGHER. I am very sorry.

Senator MIKULSKI. Well, the 70 percent was what historical number?

Dr. HOLSINGER. Somewhere between 60 to 70 percent of our patients within our system would be nonservice-connected veterans. But when you deal with the indigent patients, it reduces the number rather significantly. And that is the difference she was alluding to.

Senator MIKULSKI. At least two-thirds of the normal VA is not necessarily service connected.

Dr. HOLSINGER. That is correct.

Senator MIKULSKI. But of the nonservice connected, less than 20 percent would be indigent.

Dr. HOLSINGER. We have about 38 percent service-connected veterans on average in our system.

PSYCHIATRIC CASUALTIES

Senator MIKULSKI. Mr. Coronado, did you want to say anything about the psychiatric?

Mr. CORONADO. I think an interesting point that you have read about in the papers is the fact that our psychiatric units are being pressed these days because the Vietnam era veteran is having trouble with flashbacks. And I believe the psychiatric teams are continually working with the veterans who have these problems and they will be ready for any call that might be made of them during this time.

Senator MIKULSKI. That is an interesting phenomenon.

You know, when one talks to the Vietnam vets, they always refer back to the way they were greeted—the hostile way they were greeted, or the callous way they were greeted, when they came home. There is such a tremendous spirit of support for the men and women in the field. Do you think that in and of itself is a tremendous morale booster? It is no substitute for what they will see in battle, but will that, in and of itself, help? The spirit that the country has of welcoming them back, not only to the hospital, but on the job, the support that is going on?

Secretary DERWINSKI. Madam Chair, you are too young to remember, of course, but during Vietnam, the pattern was that the serviceman came home alone. He was drafted, served his 2 years, came home. Hopefully, this time, they will come back in units, the same units that were called up as reservists, or the regular units, they will be coming back to their home bases at their hometowns.

I think that kind of warmth and reception and the accolades and respect and appreciation that—for example, I experienced coming back from World War II and the veterans experienced all through that period of World War II—I think that will be the pattern here. Hopefully, it will make a great difference.

WOMEN CASUALTIES

Senator MIKULSKI. I would also go to the issue of women casualties that was raised. There used to be a saying in the military that if you were in the rear with the gear, you had nothing to fear.

Now, the women who have been called up in the Reserve units are primarily in medical personnel, and we all know that our military nurses have always been prime targets and have suffered casualties, both physical and emotional. But the women who are flying cargo planes, logistical support, and so on, are also in this battle prime targets.

What type of special casualty needs do you anticipate? I know that we are talking about the burns and the orthopedic problems and the psychiatric. But are there any others that are anticipated?

Dr. HOLSINGER. I think, Madam Chair, one of the key points to make as far as women casualties returning, is that the VA has the authority to place a female veteran, or in this case, a female service person returning, directly in community care. We cannot do that as far as male patients are concerned, but due to some of the limited nature in the past of some of our ability, particularly for privacy issues, to care for female veterans, we have that legislation.

As a result of that, if a woman returning requires specific GYN care, we have the authority to place them directly in community care, and we will do that. Also, because of our strong relationships between the VA and the medical schools, every one of our facilities has GYN consultants, and we would bring those individuals into play if it was something we could care for within our medical center. I think that we have that authority.

Mr. CARROLL. That is correct, Madam Chair.

STAFFING

Senator MIKULSKI. I have two other areas of questioning coming back to staffing and cost. This goes to the need for adequate staff. What is clear is that VA did suffer a loss due to the callup of reservists, some in an uneven nature. What is very clear is that these are not people not readily replaced. They are highly trained. They are trauma physicians. They are nursing, for which there is not a large pool out in the community, lab technicians and others. What are your plans for dealing with this?

For example, where reservists are now called up and it would really deplete perhaps a particular hospital's ability to respond now, is there any thought for saying that since they are going to be possibly dealing with casualties anyway that they should stay? The issue of bringing back the retired or going for a waiver at OPM? Something along those lines? Can you kind of tell us what your thinking is as you go through that? Any obstacles you might have in resolving that?

And I do not know what is a good plan or a bad plan, but I do know for example, in Baltimore we have a very highly skilled surgeon that was called up and he is not sure if he is going to go to the battlefield or be sitting up in another medical facility pushing papers when we need him either at battlefield conditions or at postbattlefield conditions, at our VA hospital.

Dr. HOLSINGER. Madam Chair, first of all, we have as of January 17, 1,923 individuals called up. Of those, 194 are physicians and 734 are nurses. Now this may sound strange, but I have less concern

about the physicians because of our relationship with the Nation's medical schools.

Senator MIKULSKI. It does not sound strange to me, Doctor.

Dr. HOLSINGER. But the nurses are the point where my greatest concern is. I believe, for example, if I have lost respiratory therapists that under our contracts with the schools, our sharing agreements, we can get respiratory therapy accomplished. I believe, without question, if we run out of time on our own CAT scanners, we can buy that time on the university CAT scanners and so on.

The issue is really nurses because they are in such short supply across the whole country. I think, as Ms. Gallagher has indicated, we have moved to look at the pool of nurses.

We certainly would be interested, as Mr. Coronado indicated, to bring back any nurses that have just recently retired on a waiver for the dual compensation issue. We are certainly interested and would move to offer nurses within the community who might not be working, but who have valid credentials—that is, a license, a current registration of their license—the opportunity to come to work for us, even for a short period of time, parttime, specific hours, and so on, in order to beef up and bring some nurses back into active nursing that at this point in time might not be currently practicing.

Each hospital is, I am quite sure, very diligently working and looking at how they can handle that.

Now the other thing, we do have an ability because we are a large system and we are spread across the United States, and we have certain areas where the impact of returning casualties would obviously not be nearly as great as it would be in others, we have the ability to detail people from one facility to another. So part of our plan is to consider detailing nurses out of areas where we may not have nearly as great an impact into others where there is a greater impact for whatever period it might take. We will place them on travel orders and detail them and bring their credentials with them.

The nice thing about it is that our system only requires that you have a license to practice in some State or territory of the United States. It does not necessarily have to be the one in which you practice.

SALARY STRUCTURE

Senator MIKULSKI. These are going to take a lot of innovations dealing with other Federal agencies, and we look forward to, if necessary jaw-boning this because I think these will be unusual times. People do want to serve.

This then takes me to cost. Let us go to the nursing issue. First of all, hiring temporary people usually means you have to pay premium pay. Do you envision yourself even being in a bidding war with civilian hospitals to get people in?

Dr. HOLSINGER. Unfortunately, until the new pay legislation for nurses goes into effect on April 1, that was passed by the last Congress, we will not be able to get into a bidding war. Right now our ability to pay to some extent is based upon the current pay schedules.

However, the place where the cost comes about for us is through going to the pool nursing activity and this sort of thing where the price is high, although we can get the individuals. The result of it is that yes, we are already generating additional expenses. To date, it has been in the range of about $800,000 that has been reported to us from our facilities that they have had to expend to be able to bring in individuals from pools and so on.

Senator MIKULSKI. Doctor, I would like to bring up the issue of locality pay. Maybe we should have had Connie Newman here, who I admire tremendously, I must say.

But let us look at it this way, when Ms. Gallagher goes to recruit out in Baltimore, Baltimore is not in locality pay; Walter Reed is. So if you are a nurse and you have an opportunity to serve, unless—you say Walter Reed is putting out a call and I am not saying this is the way the plan works, but where, San Francisco or whatever, that there is someone ready for duty with an up-to-date license, that there would be a difference of at least 8 percent in pay because of an extra 35-minute drive.

Will you be looking at that as an issue?

Dr. HOLSINGER. Yes; and in point of fact that is what is underway due to the new pay legislation for nurses. We will be going to a strict locality-based system by April 1.

For example, Ms. Gallagher will have had to have conducted a study within Baltimore to determine what the pay ranges there are. She will set the pay for her nurses based upon the rates it will take for her to be able to hire individuals.

Up until April 1, we are in a position where we are working on a national pay system and that changes as of April 1.

Senator MIKULSKI. Ms. Gallagher, do you want to talk about that? I do not know if San Antonio is in the same situation, but you know we draw these arbitrary lines and somebody's locality pay is premium and then a week away it is not. And sometimes we are talking about members of the same family.

Ms. GALLAGHER. It is not only a problem with nursing, it is a problem with all of our people that we try to hire because of the locality pay. Retention in our hospitals is an important issue and we do lose people to Fort Meade who are not necessarily clinical people. So it is an issue. The locality pay needs to be addressed. No question about that. It is hard enough to get nurses, but if we do not have the locality pay it is going to be even harder.

Dr. HOLSINGER. Part of that issue is that most of those individuals, when they are hired in DOD, are hired under the general schedule. They are GS employees. In our case they are hired under title 38, which is the VA health care system.

Senator MIKULSKI. I think this is something we really need to kind of straighten out, that there is a great deal of problems that are developing now over these lines.

Mr. Coronado, are you facing the same kind of problem in San Antonio?

Mr. CORONADO. Our problem is with the private sector. The private hospitals have many ways of enticing nurses to work for them. Last month I ran into one situation where the hospital paid for 1 day a week for a maid for the nurse who would work the evening shift. There is no way we can compete with that.

Senator MIKULSKI. You mean they were hiring somebody who was not qualified?

Mr. CORONADO. They hired nurses who are qualified. But for the nurse, to help her at home, they would hire a maid to work for her in the home 1 day a week. That is as a benefit for working in that private hospital.

COST OF CONTRACT STAFFING

Senator MIKULSKI. I wonder what they are going to charge the VA if we have to contract out?

This goes to an issue where again of the reimbursement of civilian hospitals, now in Maryland we have a Hospital Cost Review Commission which sets rates.

But my question is, at what rate would VA or DOD VA reimburse a civilian hospital when it cares for a casualty of Desert Storm?

Dr. HOLSINGER. We would reimburse at the HCFA rate. We have gone to reimbursement now for all reimbursements we do, at HCFA rates, so it's a health care financing requirement at the administration rates.

Senator MIKULSKI. Is that what the interagency reimbursement rate is?

Dr. HOLSINGER. No; the interagency reimbursement rate is a rate that is determined between the VA and DOD; it is not HCFA. It is a lower rate.

Senator MIKULSKI. But the Health Care Finance Agency has a great deal of expertise in rate setting. Actually far more than either you or DOD because it deals with all of the civilian hospitals.

Dr. HOLSINGER. That is why we made the decision that we would pay HCFA rates rather than actual charges. We are doing the same thing that is done under Medicare.

Senator MIKULSKI. The HCFA rates have often been negotiated because they are Government-based rates as compared to private insurance rates.

Dr. HOLSINGER. That is correct. That way, by using their rates, we do not have to negotiate new rates.

Senator MIKULSKI. So we will not be picking up a lot of their overhead and so on. So we will be using HCFA rates?

Dr. HOLSINGER. That is correct.

Senator MIKULSKI. That is pretty much their DRG rate. Am I correct?

Dr. HOLSINGER. That is my understanding; yes, madam.

Senator MIKULSKI. What about the service-connected vets that might be going to civilian hospitals? Will they also be at the HCFA rate?

Dr. HOLSINGER. Right. We would be surprised if we had to send any service-connected veterans from our facilities to private sector hospitals. If we did, we would reimburse on HCFA rates.

TRANSPORTATION COST

Senator MIKULSKI. Let me just go to the issue of transportation because I know you cannot estimate the cost of that. But now we

see how there possibly needs to be some reprogramming, redirecting, and how you very definitely will be in a crunch when we hit the fourth quarter. Is that correct, Mr. Secretary?

Dr. HOLSINGER. One of the things, though, that I was not aware of is in the note Mr. Fears passed to me. It says we can spend our accounts receivable from DOD just as if it were cash to help our cash flow. So once we have established the funds as an account receivable with DOD, we can go ahead and authorize, for example, Baltimore or Audie Murphy, to expend those funds as if they had them. So that would materially help us.

Senator MIKULSKI. One of the issues—we will be taking the veterans that you are moving from the primary hospitals to secondary hospitals in those areas. Now the casualties will be cared for by DOD and their transportation will be. For those that will move out of Audie Murphy, out of Lockraven to their sister counterparts, who will pay for that transportation?

Dr. HOLSINGER. We will pay for care of veterans and that includes their transportation if we need to clear the beds. We will be reimbursed by DOD for all costs associated with their patients that we care for, including transportation costs and so on.

Senator MIKULSKI. But the local VA hospitals will have to make their arrangements and pay their own bills, is that correct?

Dr. HOLSINGER. That is correct.

Senator MIKULSKI. Will it be paid for out of their operating budgets?

Dr. HOLSINGER. Yes; out of their operating accounts.

Senator MIKULSKI. That means if you are not one of the primary care designees, the AD will have more stress on them, is that not correct?

Dr. HOLSINGER. That is correct. We will be monitoring those kinds of expenses in the cost distribution reports on a regular basis from a central perspective. We will make sure that they have the funds that they need to work with. We anticipate that, with the flow of funds from DOD to care for the returning casualties, our funds, hopefully, will be sufficient to care for the needs of the veterans.

Senator MIKULSKI. Is headquarters giving any kinds of suggestions to the local AD primary care centers on how to do that? For example, I discussed with Ms. Gallagher the possibility—I know she has already been contacting private services. But there are local governments who, perhaps, if the need is not overwhelming where there would be some sharing of that. This is a tremendous time where I think local governments and nonprofits would be interested in volunteering or a private would be interested in a reduced rate.

Are you giving that type of guidance?

Dr. HOLSINGER. Each VA medical center has been informed of their need to develop their own transportation plan. That is as far as what it takes for them to either obtain patients at the airport and bring them to their facility or to move their patients, whether they be casualties or their own veterans, to another facility. They are utilizing their contracts and their contacts within the community in order to do that.

Senator MIKULSKI. Ms. Gallagher, Mr. Coronado, do you want to comment on that?

Ms. GALLAGHER. That is correct. We have lined up at least 10 ambulance companies. We are hoping that some of the patients that we transport will be through the DAV; they have vans that can transport patients to our sister hospitals as well. We also talked to the city and we were given assurances that they would help us in an emergency crunch.

Senator MIKULSKI. The city and surrounding other counties?

Ms. GALLAGHER. Right; so I think we can handle the transportation. There will be extra costs. We have laid aside a cost center for that locally so that we know exactly what the transportation costs, contingent on what the casualty situation will be.

Mr. CORONADO. That is correct. I would like to support what Ms. Gallagher has said. Accounting systems have been set up to track unusual costs related to the VA-DOD contingency plan. In our area the Army has accepted the responsibility of transporting patients from the reception center to the hospital.

Moving patients to the secondary hospitals is our responsibility. We will either use contract ambulance or other means available to us to get the patients to the secondary hospital.

Senator MIKULSKI. Well I think we have covered a lot of ground here today. It is really an extraordinarily complex plan of staffing and coordination and cost agreements. It sounds like the plan is in place and ready to go.

Hopefully, all this preparation will not be needed. But if it is, it sounds like that——

Mr. Derwinski, let me ask you. Are there any things you think we need to be aware of and ready to do at this time?

Secretary DERWINSKI. Well, of course, sooner or later all of this will have a budget impact. Your committee has been especially understanding with us the last 2 years. We look forward to what I think we would call a logical continuation of that.

We have to say that, in the last 6 months, because of the preparation we have been required to go through, we are a better system than we were 6 months ago. We have dusted off assets we did not realize we had. We have made better utilization of them.

By very fascinating coincidence, Dr. Holsinger came aboard August 6. Steve Trodden came aboard at the same time. We have just had an excellent group of people converge at the right time and in the right place. We expect to meet the challenge.

We will be reporting directly to you and want you to know how much we appreciate your early interest as well as your sustained interest.

Senator MIKULSKI. We are going to continue that. We really are. When I visited the Baltimore facility I was struck by what you say, the high degree of morale, the commitment, the willingness to make a tremendous amount of personal sacrifice to be there.

What I so liked about the Baltimore facility I am sure is true in the other 79 primary care facilities, was that people were moving quietly, but with a quick pace. There was no panic. There was no hysteria. There was a real quiet, determined, obviously sustained, and quick pace. There was a sense of urgency, but there was not

the chaos that sometimes comes. That really was enormously reassuring.

I said that on Baltimore TV because, to the families, the spouses, the parents of our troops in the Persian Gulf, they just want to know we are ready to back them up. I can only say that I found the morale high. It was enormously reassuring.

I do not know if the Congress will be equally as quiet, but I am ready to move as quick-paced. With that, I ask our inspector generals, is there anything we have not covered or asked, either from the overall inspector general or the medical inspector general that you think needs to be raised or we need to be aware of now? Do you think we have covered everything?

Mr. TRODDEN. It has been a comprehensive hearing, Madam Chair.

Senator MIKULSKI. I thank everyone for their cooperation.

ADDITIONAL COMMITTEE QUESTIONS

We will submit the balance of the questions for response in the record.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED BY SENATOR MIKULSKI

VA Preparedness for the Contingency Plan

SENATOR MIKULSKI: Who has principal responsibility for monitoring the quality of care that a Desert Storm GI would receive - VA or DOD? What about if the GI is placed in a civilian hospital?

ANSWER: VA would maintain responsibility for monitoring quality of care for patients placed in VA medical centers. DoD maintains responsibility for quality of care in DoD facilities. Each Department will evaluate continuity of care for patients placed in civilian hospitals.

SENATOR MIKULSKI: If VA had to provide all 25,000 beds it has pledged under the Contingency Plan, how many non-service connected veterans who now rely on VA for medical care could lose care altogether?

ANSWER: The 25,000 beds are to be made available in the long term (within 30 days). VA's current contingency planning includes a count of beds available to DoD, limited by available VA staff. The current available staffed beds reported for use by DoD within 72 hours is approximately 15,000. Any emergency care will be provided, however, non-emergency admissions of non-service connected (NSC) veterans may be deferred depending on the contingency situation.

SENATOR MIKULSKI: Could you provide as many as 25,000 beds for the Contingency Plan if all 12,500 reservists in VA hospitals were called up?

ANSWER: With the current level of activation, VA can provide approximately 15,000 beds within 72 hours. If additional reservists are called up, it may reduce the number of beds VA could make available to DoD.

SENATOR MIKULSKI: When will the Inspector General perform follow-up work to ensure that the problems he identified in his recent investigation are being corrected?

ANSWER: The Office of Inspector General plans to finish a report on VA/DOD contingency planning by the end of February, 1991. This report will include a follow-up review on the validity of bed availability data and the effectiveness of the VA Medical Inspector's methodology for reviewing bed availability data.

SENATOR MIKULSKI: How do you ensure the accuracy of the bed availability data reported by the civilian hospitals which are part of the National Disaster Medical System?

ANSWER: Approximately 110,000 community beds have been pre-committed to the National Disaster Medical System (NDMS) through better than 1600 Memoranda of Understanding (MOU). The Department of Veterans Affairs is responsible for 34 areas of the United States so far as NDMS and VA/DoD Contingency matters are concerned. These Area Managers are required to review the MOU's on an annual basis to make sure the community hospitals are capable of providing a minimum and maximum number of beds. It is important to mention that these MOU's are management tools only - not binding contracts. Thus, it is more prudent to state that community hospitals could provide a range of between 59,000 to 110,000 beds available if called upon by the activation of either the NDMS or the VA/DoD Contingency Hospital Plan.

SENATOR MIKULSKI: Will the rate at which DOD reimburses VA for patient care cover all VA's costs, in all instances, for treating Desert Storm casualties? If not, could you elaborate for which specific areas of care? How are those per diem reimbursement rates determined?

ANSWER: The reimbursement rate is the Interagency Billing Rate for Fiscal Year 1991 established by Office of Management and Budget (OMB). In addition the VA will be reimbursed for any transportation and prosthetic costs incurred. The VA will be tracking costs incurred and match those costs to the reimbursements to determine the actual budget impact of Desert Storm.

SENATOR MIKULSKI: How much has it cost VA to date to hire medical employees to replace those called up on reserves as a result of Desert Storm? How much has been spent on overtime to compensate for those reservists called up?

ANSWER: Through the first quarter of FY 1991 we estimate that it has cost us approximately $800,000 to contract for replacement services in our facilities. This cost is fully offset by the salary dollars we are not spending on the mobilized employees.

SENATOR MIKULSKI: Does VA have special needs in terms of equipment to handle chemical burns or other types of injuries which may result from Operation Desert Storm casualties? provide a list and associated costs. How will VA's current priority list of equipment needs be altered by caring for Desert Storm casualties?

ANSWER: It is not anticipated that the current priority list of equipment needs will be altered as a result of Desert Storm activities. The VA currently has the equipment necessary to support the beds that are being reported to ASMRO. It is generally felt that VA medical centers can quickly rent or purchase equipment to augment capabilities due to heavier than anticipated workloads of particular kinds of injuries.

QUESTIONS SUBMITTED BY SENATOR LEAHY

VA Preparedness for the Contingency Plan

SENATOR LEAHY: What are the guidelines VA hospitals will be given for transferring hospitalized veterans to civilian hospitals in order to make beds available for military casualties?

ANSWER: VA contingency plans call for discharge of medically stable NSC patients. Medical centers will have clinical services assess the status of current inpatients to plan to discharge medically stable patients if necessary to meet bed availability needs. Provisions will be made to assure continuity of care for all patients discharged. The assessment will also determine appropriateness of transfer of patients to secondary VAMC's or the community. There will be no discharge or transfer of patients deemed clinically inappropriate and VA will maintain responsibility for continuity of care.

SENATOR LEAHY: Mr. Secretary, how will local VA hospitals be reimbursed to support additional staff, overhead and hospital care of casualties resulting from Operation Desert Storm? When will emergency funds be made available to local hospitals to support these new expenses?

ANSWER: The VA has entered into an agreement with DOD that will allow for monthly billing for treatment of casualties treated as a result of Operation Desert Storm. Each month a bill will be prepared and the medical facility providing the service will receive reimbursement for the services provided. In determining the actual budget impact of Operation Desert Storm, the VA will: (a) compare the contract care cost of displaced VA patients to in-house costs; (b) compare the costs of care provided to DOD patients to DOD reimbursements; (c) identify training and administration cost; and, (d) identify the net effect of the costs and savings associated with VA medical care personnel who are activated to military duty. The analysis of the information from (a), (b), (c) and (d) above will be the basis for identifying the budget impact of the VA/DOD contingency system on the VA medical care system.

SENATOR LEAHY: Mr. Secretary, what are the guidelines and reimbursement formulae for supporting post-discharge outpatient care of casualties from Operation Desert Storm who remain in the area of a VAMC following hospitalization?

ANSWER: If a Desert Storm casualty is discharged from a VA medical center and has not been discharged from the military base with the exception of the Navy personnel. The Navy has indicated that they will send their service person home for further recuperation.

Thus, in this scenario, VA would have no financial commitment for these service personnel.

If the person has been discharged from the military, the person is a veteran and the VA would no longer receive reimbursement from the military for these patients. VA will keep track of the care provided to these veterans and if necessary will seek supplemental appropriations to provide for their care.

SENATOR LEAHY: Mr. Secretary, what mandate do Vet Center staff have for participating in inpatient and outpatient care of casualties from Operation Desert Storm?

ANSWER: As part of the VA/DOD contingency plan, vet centers will assist VAMC mental health services in whatever way is needed for the care of returning casualties assigned to the VAMC. Vet center staff will participate in the general mental health response at VAMCs, reporting to whomever is designated by the VAMC director. In addition, on January 29, 1991, VA submitted a legislative proposal to Congress extending eligibility at vet centers for readjustment counseling services to all post-Vietnam era combat veterans which would include returnees from Operation Desert Storm.

SENATOR LEAHY: Mr. Secretary, will there be resources available and is there a mandate for local VA hospitals to provide services to families of casualties?

ANSWER: Families of casualties will have access to an 800 number which will be equipped with twenty phone lines to accommodate the calls. Veterans Benefit Counselors will be available at contingency planned facilities to provide advise and counseling to families on veterans benefits. Under Title 10 U.S.C., when a patient remains on active duty or receives a medical discharge from the military, family members retain their entitlement to CHAMPUS.

SENATOR LEAHY: Mr. Secretary, what is the eligibility of military reservists or guardsmen who are deployed as a part of Desert Storm for inpatient and outpatient treatment at a VAMC? Is there any change in their eligibility prior to activation and deployment?

ANSWER: Military reservists or guardsmen who are deployed as a part of Desert Storm who are released from active duty after completing the full period for which they were called or ordered to active duty will become veterans. These veterans will be eligible for inpatient and outpatient care at VA medical centers.

QUESTIONS SUBMITTED BY SENATOR GARN

VA Preparedness for War Casualties

SENATOR GARN: I have long maintained that the principal mission of the Department of Veterans Affairs is to care and assist those who have served in the military and have been disadvantaged or suffered injuries as a direct consequence of that service. Much of my concern over the adequacy of the Department's activities is based on my view that the VA has become a special welfare agency for all who happened to serve in the armed services at one point in their lives. This has diminished the proper focus on delivering the finest care and assistance possible for those injured or wounded in military service.

The current military actions in the Persian Gulf, and the potential for large numbers of casualties has again focused attention on the role of the Department in assisting "those who have borne the battle."

Although the potential budgetary impact of the Persian Gulf war is not an issue to be covered by this hearing, it is useful for us to better understand the arrangements between the VA and the DoD as to which agency is responsible for the cost of providing services to those requiring medical attention as a consequence of hostilities. Please detail the financial arrangements between the two departments as to how such costs will be shared?

ANSWER: The VA and DoD have an agreement that established the interagency billing rates, set by the Office of Management and Budget (OMB), as the billing rates for treatment of casualties. In addition to the interagency rate the VA will also bill for transportation and prosthetic costs incurred in the treatment of casualties. Each branch of the service will be billed monthly for the services provided by the VA. The billing rate plus the additions for transportation and prosthetic costs should cover the costs incurred by the VA. Therefore until the patient is medically discharged from active duty and becomes eligible for care by the VA, the costs will be borne by DoD on a reimbursement basis.

SENATOR GARN: It is my understanding that the Department of Defense will discharge wounded personnel that are not expected to return to military service. Please explain the Department's policy regarding discharge of such personnel, and to what extent the DoD will remain responsible for continuing care and assistance to such individuals and their dependents.

ANSWER: When the Department of Defense medically discharges patients that are being treated in VA Medical Centers, these patients become the responsibility of the

Department of Veterans Affairs for future medical care. When a patient receives a medical discharge from the military, family members retain their entitlement to CHAMPUS.

SENATOR GARN: Should a discharged person be confined to a military hospital, does the provision of medical services become a responsibility of the Department of Veterans Affairs at that point? Please explain how the two Departments will handle transfer of such these individuals to assure no disruption of care.

ANSWER: Patients who are receiving medical care in a military hospital at the time of their discharge from active duty will remain the responsibility of the Department of Defense until they are either discharged from the hospital or transferred to a VA facility. Transfers between DoD and VA medical facilities will be coordinated by the Armed Services Medical Regulating Office.

SENATOR GARN: We have heard much discussion of the cost of the Persian Gulf war. No doubt that it will be a long time before a comprehensive assessment is possible, but it is clear that with respect to casualties of that conflict, there will be substantial costs associated with medical care and other long-term assistance. Does that VA have any statistical information estimating costs associated with the long-term entitlement for care for those wounded or injured in military service?

ANSWER: The VA does not have systems in place to track costs for an individual veteran over the long-term. In any given year we can estimate average costs for the veterans that come to the VA for care.

- During FY 1990 the Department of Veterans Affairs treated 234,808 service-connected veterans in an inpatient setting. These veterans accounted for 6,814,304 patient days of care at an average cost of $10,600 per service-connected veteran.

- During FY 1990 the Department of Veterans Affairs treated 978,424 service-connected veterans in an outpatient setting. These veterans accounted for 10,080,706 outpatient visits at an average cost of $114.05 per visit. This resulted in an annual outpatient treatment cost of $1,175 per service-connected veteran.

- During FY 1990 we estimate that 31% of service-connected veterans received either inpatient or outpatient services from the VA.

QUESTIONS SUBMITTED BY SENATOR D'AMATO

Primary Receiving Centers

SENATOR D'AMATO: The VA has designated 80 VA medical centers as 'primary receiving centers'. Eight of these are in New York. Could you describe in detail the role that these centers would play in the VA/DOD Contingency Plan?

ANSWER: A total of nine (9) VA Medical Centers in the State of New York could potentially be called upon to receive casualties from the Persian Gulf War. They are as follows (in priority of receipt): Bronx, Manhattan, Brooklyn, Buffalo, Albany, Syracuse, Northport, Castle Point and Montrose.

These VA medical centers could be called upon to perform the following functions:

- Identify the number of available and staffed operating beds that could be used for incoming DoD casualties;

- Assemble a VA medical team that would go to the airport and sort (triage) patients based on their severity. Most patients would be admitted into a VA hospital and others would either be transported to a community health care facility or a secondary VA medical center.

- Patient tracking and disposition would also be conducted at these VA facilities.

SENATOR D'AMATO: How did you determine which VA medical centers would be so designated?

ANSWER: These sites were selected based on:

- Availability to an airport (triage);

- Medical services that could be provided by that facility; and,

- The number of community hospital beds that could be used if the VA medical center reached capacity.

Advance Notice of Casualties

SENATOR D'AMATO: Timely information about the number of incoming casualties and the nature of their injuries is obviously critical for those responsible for Emergency Management in each state. It is particularly important in areas like New York City, where logistics can be very complicated.

Can you assure us that information will be made available enough in advance so that such areas will not be caught unprepared?

ANSWER: All receiving hospitals will be notified by the Armed Services Medical Regulating Office (ASMRO) when they are to receive patients. They will regulate patients only when they have been advised by those hospitals that they can receive these patients. Any hospital will have at a minimum 8 hours advance warning that they will receive casualties for their installation. Systems are in place and exercised annually for the integration of civilian, state, and federal medical readiness. In an exercise last year, 500 "victims" were moved from Fort Drum New York to 6 cities in 4 states (including New York) by airlift. The triage, treatment and transportation mechanisms utilized all emergency services, state, local, federal to include the closing of the Holland tunnel for patient movement to Brooklyn and Manhattan.

Health Provider Education

SENATOR D'AMATO: VA physicians are used to dealing mainly with the health problems of an aging veteran population.

What are you doing to prepare these physicians for the kinds of combat injuries we might encounter in Operation Desert Storm (such as combat stress, chemical weapons injuries, and ballistic injuries).

ANSWER: The training and education programs coordinated by the Department of Veterans Affairs, Emergency Medical Preparedness Office, has been the most expeditious, efficient and effective means of preparing physicians and other clinicians for their potential roles in treating Operation Desert Storm casualties. Using the "Train the Trainer" approach has ensured fast dissemination of valuable information throughout the Department of Veterans Affairs health-care system.

Content experts within the Department of Veterans Affairs, Department of Defense (DOD), Federal Emergency Management Agency (FEMA) and civilian sector have been identified. Specific inquiries are directed to these experts by the Emergency Medical Preparedness Office, Training Education Research and Development section staff.

The training and education that has been planned and executed is directed toward preparing the Department of Veterans Affairs' administrative, clinical and support personnel for the potential role of treating casualties from Operation Desert Storm. Thus far, training and education have been:

a) September 19, 1990, - 3 hour teleconference
Target Audience Department of Veterans Affairs administrative, clinical and support staff.
Topics - VA/DOD Contingency Hospital System, Infectious Disease, Chemical Agent Injuries, Combat and Traumatic Stress
Presenters - Experts from Department of Veterans Affairs and Department of Defense

* A segment with phone-in questions/answers was included.

b) November 27 - 30, 1990, Northport, New York, Regional Medical Education Center (RMEC) and December 4 - 7, 1990, Aberdeen Proving Grounds, Maryland
Medical/Surgical Update: VA./DOD Contingency
Target Audience - Physicians and Registered Nurses from 22 primary VA-Medical Centers - Initially identified as casualty reception sites.
Specialties in attendance: Ambulatory Care, Surgery, Infectious Disease, Infection Control, Pulmonary Medicine.
Topics - VA/DOD Contingency Hospital System, Ballistic Injuries, Trauma Medicine, Infectious Disease, Infection Control, Chemical Agent Injuries, Decontamination Procedures, Traumatic Stress.
Faculty - Experts from the Department of Veterans Affairs, Department of Defense, Federal Emergency Management Agency (FEMA), civilian sector.

c) December 18-20, 1990 - Ft. Benjamin Harrison, Indiana - Interventions in traumatic Stress - VA/DoD Contingency
Target Audience - Mental Health workers from 22 initial primary VA Medical Centers and corresponding Vet Centers.
Topics - VA/DOD Contingency, Medical/Surgical Overview, Current military operations, Traumatic Stress Interventions.
Faculty - Department of Veterans Affairs, Department of Defense, and FEMA.

d) January 9, 1991, 90 minute teleconference on VA/DOD Contingency
Target Audience - Administrative, clinical, and support staff at all Department of Veterans Affairs facilities Topics - Activities of VA Medical Centers in contingency operations.
Presenters - Experts from Department of Veterans Affairs (national and local perspectives), Armed Services Medical

Regulating Office (ASMRO), Patient Airlift Command (PAC).

* A segment with phone-in questions/answers was included.

e) January 9, 1991, a 60 minute teleconference on Bed Reporting Using Forum Computer System
Target Audience - Appropriate staff at VA Medical Centers responsible for bed reporting
Topics - VA and DoD's respective roles and link with FORUM, practical applications with ADP bed reporting Presenters - VA and DoD experts in FORUM

*A segment with phone-in questions/answers was included.

f) January 22 - 24, 1991 and February 5 - 7, 1991, Northport New York, RMEC -Medical/Surgical Update: VA/DoD Contingency

* Workshops are 'repeat' of first Medical/Surgical workshops but will include clinical staff from the 58 remaining primary VA Medical Centers. In addition, these individuals will receive 'Train the Trainer' component including audio visual and printed materials to assist them in training their colleagues, staff and secondary VA Medical Centers, adjacent DoD facilities and local community agencies.

** Videos and presenter slides of entire workshops have been sent to the medical libraries of the 80 primary sites.

*** Copies of Medical/Surgical training materials and chemical injury texts have been sent to ALL VA Medical Centers.

g) February 19 - 21, 1991, Northport, New York, RMEC, Interventions in Traumatic Stress: VA/DoD Contingency. This is a "repeat" of the first Traumatic Stress Workshop Target Audience - Mental health staff of remaining 58 primary VA Medical Centers and coordinating Vet Centers.

* This group will be provided with 'Train the Trainer' instructions and materials.

** Traumatic stress videos, manuals and slides will be sent to VA Medical Centers and Vet Centers.

h) By February 22, 1991, number of people trained:

Medical/Surgical Workshops	400 +
Traumatic Stress Workshops	250 +
Teleconferences	172 VA sites

(undetermined number of audience participants)

Updates, refresher courses and relevant specialty training are being planned.

Role of Civilian Burn Centers

SENATOR D'AMATO: In light of the limited number of burn beds available within the VA system, could you describe the role that civilian burn centers will play in dealing with potential chemical weapons injuries?

ANSWER: As is well known, there are a limited number of dedicated burn beds in the VA hospital system. There are, however, approximately 2000 available within the civilian community throughout the United States. These are located primarily within the major cities. Many of these centers have Memoranda of Understanding within the National Disaster Medical System (NDMS).

At the present time, DoD is planning on taking care of burn victims within their own system. This will utilize, for example, the Burn Facility (expanded) at Brook Army Medical Center, Ft. Sam Houston (San Antonio), Texas. If the numbers exceed the burn capability of DoD. The plan is to send them directly to civilian community burn centers <u>without activating</u> the National Disaster Medical System.

SENATOR D'AMATO: What has the VA done to prepare these centers for dealing with such injuries?

ANSWER: The VA has made a concerted effort to train medical personnel in all medical centers with four medical/surgical programs, (the last being the week of 4 February 91).

These 4-day sessions have included training in chemical burn injuries given by personnel from the Army's Aberdeen Chemical Defense School. All VA primary centers have been given videotapes. Selected attendees (with training aids) have been picked to train personnel at their facilities, as well as associated VA secondary facilities. All VA medical centers have received appropriate written material on chemical injuries plus other subjects germane to Desert Storm.

Spinal Cord Injuries

SENATOR D'AMATO: This question has to do with ensuring continuity of care for patients <u>currently</u> being treated by the VA for spinal cord injuries.

My concern is that since most civilian health facilities are unable to duplicate the specialized care available through the VA to spinal cord injured veterans, what will happen to these veterans if they have to be transferred out of VA spinal cord injury centers to make room for Persian Gulf casualties? Does the VA have a contingency plan to ensure that these patients receive adequate treatment in the civilian sector?

ANSWER: VA contingency plans call for discharge of medically stable NSC patients. Medical centers will have clinical services assess the status of current inpatients to plan to discharge medically stable patients if necessary to meet bed availability needs. Provisions will be made to assure continuity of care for all patients discharged. The assessment will also determine appropriateness of transfer of patients to secondary VAMC's or the community. There will be no discharge or transfer of patients deemed clinically inappropriate and VA will maintain responsibility for continuity of care.

QUESTIONS SUBMITTED BY SENATOR BYRD

Impact of the Veterans Administrations Contingency Plan on West Virginia Veterans Administration Hospitals

SENATOR BYRD: I am advised that the Veterans Administration contingency plan has categorized the four Veterans Administration hospitals in West Virginia -- Martinsburg, Clarksburg, Huntington, and Beckley -- as secondary hospitals. The secondary hospitals will provide bed space to handle any overflow patients from the primary hospitals. I commend the Veterans Administration for developing this important plan to deal with those medical contingencies which may occur as a result of the conflict in the Persian Gulf.

How will VA meet the medical care needs of our members of the Armed Forces should they exceed that level anticipated by the Contingency Plan?

ANSWER: In the event of a military contingency situation that exceeds VA's capacity, the Assistant Secretary of Defense (Health Affairs) may activate the National Disaster Medical System (NDMS) for placement of casualties in non-Federal Civilian hospitals.

SENATOR BYRD: Please provide for the record, the results of any tests conducted by the Veterans Administration to assure the coordinated efforts of all of the secondary and primary hospitals in the accomplishment of the mission of providing the necessary health care to our wounded members of the Armed Forces. Also, please indicate what, if any, coordination has taken place with community hospitals, in the event that bed space at the primary and secondary hospitals has been exhausted.

ANSWER: Historically, the VA health care system has conducted a significant number of tests in connection with its role as a medical backup to the Department of Defense (DOD) during a time of national emergency. In 1988, we participated in an exercise titled "Nifty Nugget". As a result of this exercise, a number of issues and some problems were identified, but the overall outcome was that VA and civilian hospitals could indeed backup DOD in time of war or national emergency. Similar annual tests have been conducted since that time - most recently in October 1990. Twenty-five VA medical centers tested their VA/DOD Contingency Plan during a 72-hour period in mid-October. A number of issues surrounding 1) medical reception; 2) transportation concerns; 3) communications; and, 4) command and control were addressed. Equally important, all of the 80 VA primary receiving hospitals recently reviewed their VA/DOD Contingency Plan in order to make sure they were ready to receive casualties from an overseas conflict and to assess their capability in utilizing community medical

resources. It is common practice for VA medical centers to meet with community hospital clinicians and administrators to make sure a viable triage and transportation plan exists and is "functional". Most major community metropolitan areas have a system in place that can quickly indicate the number and type of bed(s) that could be made available to augment and support the VA/DOD Contingency Hospital System.

Huntington Veterans Administration Medical Center

SENATOR BYRD: The Huntington Veterans Administration Medical Center has been designated by the Veterans Administration to receive all calls from relatives of servicemen and women involved in the Desert Storm Operation, who are being treated in Veterans Administration hospitals. The Huntington Veterans Administration Medical Center will use an 800 number, along with twenty phone lines to accommodate the influx of calls. Please provide for the record a summary of the steps that have been taken, to date, to adequately staff this activity. May I also have your assurances that this staffing level can and will be maintained during this critical time?

With the sensitive nature of this activity, what type of training will the individuals manning the phones receive? Please provide the scope and objectives in the training of these individuals.

Has there been any thought given to increasing the number of phone lines and staffing in the event that twenty phone lines prove to be inadequate? Please provide for the record a description of the implementation of such a plan.

ANSWER: It has been determined that a minimum of eight (8) Full Time Employee Equivalents (FTEE) would be required to staff the Unit on a 24-hour basis. Currently, eight (8) GS-4 level employees have been hired and trained to man the Central Information Center and are now on duty. An additional ten (10) individuals were hired on an interim basis for training purposes and then released. These ten individuals have agreed to be available for re-hire on short notice to further staff the Center should that additional staffing become necessary. No problems are foreseen which would hinder our ability to maintain this staffing level.

To make this Unit functional in the shortest time frame possible, an initial sixteen (16) hours of intense training was provided to the individuals selected to staff the Unit. Training was provided in such areas as VA regulations pertaining to release of information, equipment operations, and specialized training from Social Work Service on crisis intervention. Staff from the VA Regional Office provided training on handling

calls and providing information on veterans benefits for those who might inquire. Training is continuous and will continue throughout the activation period of this Unit.

Objectives in the training of these individuals are:

a. To provide technically qualified operators capable of fully utilizing the equipment provided for assimilating and disbursing of information;

b. To insure that each employee is capable of meeting the dual goals of providing appropriate information in a clear and concise manner and to do so compassionately; and,

c. Assure that selected employees are able to handle crisis calls.

Martinsburg Veterans Administration Medical Center

SENATOR BYRD: The Emergency Facilities Operations Center, at the Martinsburg veterans Administration Medical Center, provides vital support to the Armed Services Medical Regulating Office (Command Center) at Scott Air Force Base in Illinois. The Martinsburg Emergency Facilities Operation Center provides vital communications, as well as being a central repository of all bed data collected from the Veterans Administration Regions. The Martinsburg Emergency Facilities Operations Center consolidates the bed data information into a finalized daily national report for the Command Center. Please provide for the record an explanation -- including additional resource requirements -- regarding the method by which the Martinsburg Emergency Facilities Operation Center at the Martinsburg Veterans Administration Medical Center will deal with the increased scope of activity, such as conducting operations on a twenty-four hour basis.

ANSWER: When the VA/DoD Contingency Plan is activated, the Emergency Facilities Operations (EFO) component of the Office of Emergency Medical Preparedness (EMPO) will expand operations to 24 hours per day, seven days per week. This will be done in accordance with the EMPO Operations Plan.

The EFO then becomes the central command and control point for EMPO activities and will continue as the information repository. The VA Central Office Command Center will utilize EFO as a key support element.

The Deputy Director for Field Management (EMPO) will be relocated to the EFO. The Deputy Director of Operations & Planning (Operations Officer - East) will also be relocated to this facility and will assist the Deputy Director for Field Management.

The Director, EFO, will insure 24-hour staffing. If necessary, current staff will be augmented with Martinsburg VAMC staff who have appropriate security clearances and addendum in their position descriptions. Close coordination with the ASMRO Liaison on bed availability issues will be maintained.

Operational hours at the EFO have already been expanded to accommodate reporting requirements necessitated by the war and events leading up to commencement of hostilities. Currently three overlapping shifts provide seven-day per week coverage from 8:00 a.m. to 12:00 p.m. EST.

Beckley and Clarksburg Veterans
Administration Medical Center

SENATOR BYRD: I am advised that the Beckley Veterans Administration Medical Center has reported that it will provide thirty-seven beds for its part in Desert Storm. Clarksburg Veterans Administration Medical Center has reported that it will have twenty-two beds available.

Please indicate whether the veterans who are currently in the system will be displaced or prematurely discharged to provide these extra beds. My concern is that veterans who have 'non-service' connected disabilities may be displaced to provide the bed space needed during this critical time. May I have your assurances that Veterans Administration will continue to provide the high level of health care for these veterans who are confined to a hospital bed that they have received in the past?

ANSWER: Planning for VA/DoD Contingency operations includes the assumption that patients will be discharged only when it is medically appropriate. The decision to discharge patients will be based on a commitment to maintain continuity of care for all veterans who are hospitalized at the time an individual medical center activates its VA/DoD Contingency response. Appropriate discharge planning will take into consideration support services available in a veteran's home and community. If a large number of casualties are received in a Primary Receiving Hospital, veterans hospitalized there may be transferred to Secondary Receiving Hospitals for continued care.

SENATOR BYRD: Please provide for the record a description of the means by which VA plans to increase staffing levels to meet the challenge posed by the Persian Gulf conflict. If no increase is expected, please provide for the record, an updated summary of how these hospitals plan to cope with the increased requirements of operating at the increased tempo which may be required.

ANSWER: Current planning by Medical Centers to receive DoD casualties takes into consideration available staff. The use of extra staff, as described below, will be necessary only if the planned capacity for VA/DoD response is exceeded. Staff increases, required because of large numbers of casualties, could then be met through a combination of overtime, fee-basis physicians, consultants, contract nurses, volunteers, and volunteer retired physicians and nurses. Many volunteers have contacted VA Medical Centers and expressed a desire to serve during the Persian Gulf crisis. Some affiliated medical schools have asked for VA credentialing and privileging of their physicians to work as volunteers. Specialty physicians, nurses, and support staff within Medical Centers have been reoriented to bed side care and assigned specific inpatient units in contingency planning. In addition, consideration would be given to detailing of VA health care providers from less critically affected facilities to those needing help.

CONCLUSION OF HEARING

Senator MIKULSKI. The subcommittee stands in recess subject to the call of the Chair. I would like to say "Hi" to the people I have not met.

[Whereupon at 11:41 a.m., Tuesday, January 22, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

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